BEATINGPULSE
FAMILY MEDICINE

PAUL A JACKSON JR FNP-BC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, give permission to Beating Pulse LLC to use and/or disclose certain protected health information (PHI) about me to/from:

_____

_____

_____

(Name(s) of entity/individual to receive/disclose information)

This authorization permits Beating Pulse LLC to use and/or disclose the following individually identifiable health information about me:

- □ Medical Records
- □ Treatment Records
- □ Diagnostic Records
- □ Billing Information/Records
- □Other: _____

Please send records to: Beating Pulse Family Medicine Clinic PO Box 12167, Murfreesboro, TN 37129, or **fax to 747-215-5340**.

The purpose of this request is "at the request of the individual," unless otherwise stated. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will ***expire 1 year from*** the date of signature below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Beating Pulse Family Medicine. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: P O Box 12167, Murfreesboro, TN 37129.

_____ _____

Print Patient's Name Patient's date of Birth

Signed by: _____ _____

Signature of Patient (or Legal Guardian) Date

_____ _____

Print Name of Legal Guardian Relationship to Patient

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST