Ideal Family Healthcare, P.C. Gregory Sharp MD PLLC

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Ideal Family Healthcare or Gregory Sharp MD PLLC to use and/or disclose certain protected health information (PHI) about me.

____ Please make a USB key that I will keep with all my records for a cost of $10 (payment enclosed).

____ Call me when the USB key is ready and I will pick it up.

____ Please mail me the USB key for a an additional cost of $5.

____ Please fax my records (no cost) to:

Provider/Facility:_____

Address:_____

Phone:_____ Fax: _____

This authorization permits Ideal Family Healthcare to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose: *Continuation of care.*

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one 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 Ideal Family Healthcare. 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 re-disclosure 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:

Ideal Family Healthcare, 335 Manitou Ave, Manitou Springs, CO 80829

Signed by: _____ _____

Print Patient's Name Date of Birth

_____ _____

Phone Number Social Security Number

_____ _____ _____

Signature of Patient or Legal Guardian Date Expiration Date for Records

_____ _____

Print Name of Legal Guardian *Relationship to patient*

Patient/guardian must be provided with a signed copy of this authorization form.