JDR

JEFFREY D. RIES, D.O.
NEUROLOGIST

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Patient Authorization for Disclosure of Protected Health Information

Patient:_____ **Date of Birth:**_____

I hereby authorize Dr. Jeffrey D. Ries, D.O. to disclose certain protected health information (PHI) to the party or parties listed below.

This authorization permits Dr. Jeffrey D. Ries, D.O. to disclose my individually identifiable health information to:

_____ Phone: _____

_____ Fax: _____

_____

Description of PHI to be released: _____

_____

This authorization will expire on: _____

Note: This form does not authorize the disclosure of any restricted health information pertaining to HIV/AIDS reports, drug and/or alcohol abuse treatment, and/or mental health information. That information will only be released with a separate authorization from the patient.

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 Dr. Jeffrey D. Ries, D.O. has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Jeffrey D. Ries' Privacy Officer at 1175 East Arrow Highway Suite J, Upland, CA 91786.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Print Name of Legal Guardian	Legal Guardian Signature	Date

_____
Relationship to Patient