JDR

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Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Jeffrey D. Ries, D.O., to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

_____

_____

This authorization permits Jeffrey D. Ries, D.O. to use or disclose my individually identifiable health information (describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

_____

_____

_____

This authorization will expire on:_____.

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 his authorization in writing except to the extent that 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 the above address.

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient's Name

_____ _____
Print Legal Guardian's name Relationship to Patient