Notice of Privacy Practices
Authorization for Use or Disclosure of Protected Health Information (PHI)

I acknowledge that I have been notified of MAXhealth Privacy Practices and understand that if I have a question or complaint that I should contact the Privacy Official. (**Patient Initials**_____).

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called PHI, Protected Health Information, under a federal health privacy law, as described below.

I, _____authorize MAXhealth, to release and obtain my private health information to/from:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Circle of Care: It is very important that we maintain an accurate list of physicians/medical providers that you see. This allows us to freely share medical information with other medical providers and ensure the highest quality of care. Please list all other Physicians with whom we may share details about your health information.

Physician Name:_____ Specialty:_____

Physician Name:_____ Specialty:_____

Physician Name:_____ Specialty:_____

Physician Name:_____ Specialty:_____

May our office leave a message on your machine? ☐ Yes ☐ No

Are there any restrictions on PHI to be disclosed? ☐ Yes ☐ No

If yes, please describe:

_____

_____

The PHI will be disclosed to confirm appointments, to render to caregivers counseling on my treatment, for prescription pickups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with MAXhealth. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at, PO Box25487, Sarasota, FL 34277*. I understand that my revocation will not affect any actions taken by MAXhealth prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative Date

_____

Patient Name Printed