Valley Medical Primary Care Inc.

6611 Clyo Road, Suite E, Centerville, OH 45459
Phone 937.208.8282 Fax 937.208.8275

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Valley Medical Primary Care, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose the following individually identifiable health information about me for the purpose(s) of treatment, payment, and health care operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have I read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

By signing, I authorize Valley Medical Primary Care to use and/or disclose certain protected health information (PHI) about me to the following individuals/institutions:

_____

_____

_____

Acknowledged and agreed to by:

_____ _____
Printed Name of Patient SSN#

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Witness Signature

This Authorization will be in force from:

Start Date: _____ End Date: _____