STEVEN M. POUNDERS, MD, PLLC

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by e-mail that you have provided to the practice. Prior to your visit, our automated system also calls your phone and gives you a non-specific message that may be left on your answering machine. If you don't approve of these methods and would like alternative reminder methods (i.e., text) please indicate those methods in the space provided.

How would you like to be contacted regarding appointments, treatment, and or other information pertinent to your healthcare and or/payment for your healthcare provided at Steven M. Pounders, M.D., P.L.L.C.? You will automatically be notified by email of appointments. *(Check all that apply)*

____ Mobile Telephone ____ Home Telephone ____ Work Telephone ____ Text

Other:____

If you have an answering machine or voice mail, may we leave messages regarding health management, treatment, and or other information pertinent to your healthcare and/or payment for your healthcare provided at Steven M. Pounders, M.D., P.L.L.C.? *(Check one)*

____ YES ____ No ____ N/A Phone Number:____________________________

If "NO", how else may we contact you regarding this information?

____

Please list any other restrictions regarding messages or reminders about your healthcare:

____

Other Uses and Disclosures: Disclosure of your health information or its use of any purpose other than those listed in the "Consent to use and disclose protected health information" page of your new patient packet, requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

____ I would like the following restrictions regarding the use and disclosure of my health information:

____

____

____

____

STEVEN M. POUNDERS, MD, PLLC

Authorization of Use and Disclosure of Protected Health Information (Cont.)

Persons Authorized to Receive Information:

Health Information Steven M. Pounders, M.D., P.L.L.C. collects or receives about you may be disclosed to the following persons:

____

Name of person / Relation / Organization

____

Name of person / Relation / Organization

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive ALL health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at STEVEN M. POUNDERS, M.D., P.L.L.C.

_____ I authorize the person(s) listed above to receive only selected health information (i.e. appointment times, etc.), which Include: ____

____

I do NOT authorize disclosure of my Health information to the following:

____

Expiration Date of Authorization:

This authorization is effecting through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to Steven M. Pounders, M.D., P.L.L.C. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure:

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

PATIENT #___________________

STEVEN M. POUNDERS, MD, PLLC

Authorization of Use and Disclosure of Protected Health Information (Cont.)

Signature:

____

Name of Patient (PRINT or TYPE)

____

Signature of Patient Date

____

Signature of Patient Representative (if patient cannot sign for self)

____

Relationship of Patient Representative to Patient