

Authorization For Use or Disclosure of Protected Health Information

Eastern Connecticut Urology

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Norwich, CT 06360

Patricia DiBattista, Privacy Officer, (860) 886-1956

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below

I hereby authorize this medical practice to use and disclose health information concerning

(Patient name and address)

as follows:

1. Treatment;
2. case management or care coordination of the individual, or direct or recommended alternative treatments, therapies, health care providers or settings of care;
3. certain other health plan communications concerning benefits; or
4. to describe a health-related product or service (or payment for a product or service) that the Covered Entity provides.

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal Privacy Rule, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____

Consent to Treat and Authorization of Payment

I (or my legal guardian or parent) authorize Franklin P. Friedman, M.D., P.C. to provide medical care reasonable by today's standards. I authorize the release of medical information necessary to process claims for medical / surgical benefits. I authorize payment of medical / surgical benefits to Franklin P. Friedman, M.D., P.C. for services provided.

Signature of Patient/Legal Guardian: _____

Date: _____