



## **AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**I authorize Noydeen Medical Group to RELEASE / DISCLOSE my health information to the following:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I authorize Noydeen Medical Group to OBTAIN my health information from the following:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Description/Dates of information that may be USED/DISCLOSED:**

Entire Record? Yes or No

Specified Dates: \_\_\_\_\_

Information will be used/disclosed for the following purpose: \_\_\_\_\_

- I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations. The information described above may be re-disclosed and no longer protected by these regulations.
- I understand that Noydeen Medical Group will be paid for the costs of copying the information to be released.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information USED/DISCLOSED under this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering a copy of the revocation to Noydeen Medical Group.

This authorization expires ninety (90) days from the date below:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative: \_\_\_\_\_ Relationship: \_\_\_\_\_