AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: ______ Choice O&P (a division of Choice Medical, Inc., 314 Erin Drive, Knoxville TN 37919) AND/OR:

____(NAME OF PERSON/ENTITY DISCLOSING INFORMATION)

To use and disclose a copy of the specific health information described below regarding:

____ _______________
(NAME OF INDIVIDUAL/PATIENT/PLAN MEMBER) (DATE OF BIRTH)

Consisting of:____
(DESCRIBE INFORMATION TO BE USED/DISCLOSED: ALL RECORDS, TYPES OF RECORDS, DATES OF RECORDS)

____

To:____
(NAME OF RECIPIENT TO DISCLOSE INFORMATION TO)

____
(ADDRESS)

For the purpose of:____
(DESCRIBE PURPOSE OF DISCLOSURE)

____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information

___ Genetic testing information

___ Mental health information

___ Drug/alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of all or some of this information, including HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure made in accordance with this authorization and prior to any revocation cannot be undone. To revoke this authorization, please send a written statement that you are revoking this authorization to: Choice O&P, Attn: Compliance Office, 314 Erin Drive, Suite 101 Knoxville TN 37919.

SIGNATURE I have read this authorization and I understand it. Unless revoked, this authorization expires 1 year from the date signed below, or at other specified date or event: ______________________________
(other date or event this authorization should expire)

By:____ Date: ____________________
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority:____

Printed Name: ____