AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize James R Webb, Jr. M.D. P.C. to release the following information to:

_____ _____
Name of Person/Organization Receiving PHI Name of Person/Organization Receiving PHI

_____ _____
Name of Person/Organization Receiving PHI Name of Person/Organization Receiving PHI

Information to be shared:

☐ Entire Medical Record ☐ Lab Results ☐ Imaging Reports ☐ All Billing Information

The information may be disclosed for the following purpose(s) only:

☐ At my or my representative's request ☐ Continued Treatment

☐ Insurance ☐ Legal

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration Date (if longer than one year from date of signature)