Patient Authorization to Use or Disclosed Protected health Information

Acknowledgement of Notice of Privacy Practices

I, ____________________________, understand Westglen Family Physicians is authorized by me to use or disclose my protected health information for a purpose not other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclosed the information, and the recipient(s) of that information. I specifically authorize any current employee of Westglen Family Physicians, or any other individual listed below to disclose my protected health information. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply)

[ ] My past/current conditions and any recommended treatment
[ ] The patient’s medical record
[ ] may we leave test results/messages on answering machines? Phone #: ____________________________
[ ] Yes [ ] No

Name(s) of person(s) authorized by this form to use and disclose the patient’s protected health information: example (spouse, child, parents)

_____________________________________________________________________________________
_____________________________________________________________________________________

I fully understand and accept the terms of this authorization.
I have received the Notice of Privacy Policies

_______________________________________   _________________________________
Patient’s/Guardian’s Signature       Date

225 Clarkson Road         Ellisville, MO 63011