

**AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED
HEALTH INFORMATION:**

I authorize my physician and/or administrative and clinical staff of LISA NATH, M.D. to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:

Phone

Relationship:

- At my request, I will be provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

- At my request, I will also be provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

- I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to **LISA NATH, M.D.**

Signature of Patient or Patient Representative

Date

This authorization expires 365 days after the date on this signed form unless revoked or terminated earlier by the patient or the patient's representative.