AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name **Date of Birth**

I hereby authorize: _____

_____

To furnish the following protected health information (PHI) to:

Michael Moffett, MD
729 N. Medical Center Drive West #221
Clovis, CA 93611
Phone: (559) 299-6600
Fax: (559) 326-2531

- ☐ Medical Records
- ☐ All records
- ☐ Information limited to the following: _____

_____

- ☐ Claims/Billing Information
- ☐ Mental Health Records
- ☐ Drug/Alcohol Abuse Records
- ☐ HIV Test Results

To be used for the following purposes: Assist in the appropriate treatment of present medical condition.

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this PHI expires.

I understand that I have a right to revoke this authorization, in writing, at any time by sending such written notification to M2 Oncology. I understand that a revocation is not effective to the extent that the office has relied on the use or disclosure of the protected health information.

M2 Oncology will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal or state law.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access).
- Request a copy of this authorization.
- Refuse to sign this authorization.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority