Authorization form

##### Your Practice Name

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **[Insert name of practice]** to use and/or disclose certain protected health information (PHI) about me to Meddkit. Meddkit is an organization that helps healthcare providers promote their practices.

This authorization permits **[Insert name of practice]** to use and/or disclose the following individually identifiable health information about me: first name, last name, email address, phone number, dates of service, referrer source, referral reason and the service type or category.

The information will be used or disclosed for the following purpose: receipt of regular newsletters and blogs, notification of important announcements, appointment reminders, appointment recalls, appointment feedback and surveys, distribution of video content to improve health or well-being.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one month after my written revocation to both **[Insert name of practice]** and Meddkit at support@meddkit.com.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **[insert name of practice]**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

**[Insert name and address of practice]**

Signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient or Legal Guardian Relationship to Patient

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 Print Patient’s Name Date

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 Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.