Authorization for the Use and /or Disclosure of Protected Health Information

Saviers Medical Group

246 E Scott St ~ Port Hueneme, CA 93041
Phone: 805.271.0708

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: _____
2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information: _____
3. I authorize the following persons (or class of persons) to receive my protected health information: Saviers Medical Group
4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to _____
6. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
7. This authorization is effective through 01/01/2050 unless revoked or terminated earlier by the patient or patient's representative.
8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Saviers Medical Group nor will it affect my eligibility for benefits.
9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations).
10. My protected health information will be used or disclosed upon request for the following purposes: Medical Care

I certify that I have received a copy of the authorization.

_____
Signature

_____
Date

_____
Name

_____
Name of Patient Representative

_____
Relationship to Patient