Jeffrey P. Block M.D., F.A.C.O.G

A Professional Corporation
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described as follows:

1. Person (s) or class of persons authorized to use or disclose the information:
2. Person (s) or class of persons authorized to receive the information:
3. Description of information that may be used or disclosed:
4. The information will be used or disclosed for the following purpose: (Note: if a patient initiates the request, the statement at the request of the patient is sufficient)
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be redisclosed and no longer protected by these regulations.
6. (If Applicable) The discloser of my information for marketing purposes is expected to the result in a direct or indirect financial benefit to (insert the name of the disclosing covered entity)
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
8. I understand that I may revoke this authorization in writing at any time by insert description of revocation process except to the extent that action has been taken in reliance on this authorization.
9. This authorization expires on ____________________________________ (insert a date or describe an event or activity related to the patient or purpose of authorization. For research authorizations, you may state "none" or end of the research study instead of including a specific expiration date or event).

________________________________ ____________________

Signature of Patient or Representative Date

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Patient Name

________________________________ ____________________

Name of Personal Representative (If Applicable) Relation to Patient