STANDARD AUTHORIZATION TO USE AND DISCLOSURE OF PHI

Groton Medical Associates
100 Boston Road, Suite E
Groton, MA 01450

Information to be Used or Disclosed

The information covered by this authorization includes:

PLEASE CHECK ONE

☐ All medical information

☐ Limited medical information as described below:

_____

_____

Please list the person(s) to Whom Information May Be Disclosed: (i.e spouse, parent, friend)

Name:_____

If you would like **no one** to be listed please check this box: ☐

Expiration Date of Authorization

This authorization is effective through (check one) ☐ ___/___/_____ **OR** ☐ NO expiration unless revoked or terminated by the person or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Office to terminate this authorization.

Potential to Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

_____

Name of Patient (Type/Print) **Date of Birth**

_____

Signature of Patient **Date Signed**

_____

Signature of Patient's Representative (if applicable) **Relationship**