HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirement of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section-130d, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Advanced Internal Medicine ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose your personal and medical information for the purpose(s) of providing your medical care.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to health providers or persons/entities specified by you.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and that permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available for Covered Entity at any of its offices or by sending a written request with return address 3416 N. Buffalo Drive, Las Vegas, NV 89129.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke the authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide _____ [name of patient] with a copy of this signed authorization.

Acknowledged and agreed by:

PATIENT:

By _____

Print Name _____ _____

Date:

Address: _____
_____
_____

or, ON BEHALF OF PATIENT

By _____

Print Name _____

As _____

Date:

Address: _____
_____
_____