PLUNDO MEDICAL ASSOCIATES

Phone 724-832-2570 Fax 724-832-2521

Authorization for USE/DISCLOSURE of Health Information

I ______________________________ authorize ______________________________

To use or disclose health information as described below regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted disease or Acquired Immunodeficiency Syndrome(AIDS) or tests for infection Human Immunodeficiency Virus (HIV).

Patient's Name______________________________ **Birth date** ______________

Last four digits of SS #:______________ For the purpose of: Continuing Care of PCP

Information is to be used by or disclosed to: Plundo Medical Associates Osteopathic, PC

Address: 518 Pellis Road, Greensburg, PA 15601

Information to Be Released (check one)

_____ The most recent 5 years of pertinent information (Chart notes, Labs, X-rays, Hospital Records, Consults and Special Tests regardless of date).

_____ Other Please specify:______________________________

I understand that the information described above could possibly be re-disclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing as described by Plundo Medical Associates Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event: ______________. If I fail to specify an expiration date or event, this authorization will expire in 90 days.

I understand that Plundo Medical Associates may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research related treatment.

Signature______________________________**Date**______________

If signed by Legal Representative, Relationship to Patient______________________________

Witness Signature______________________________**Date**______________