Mary Louise Lenahan, MD

Authorization of Use and Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (PHI) by Mary Louise Lenahan, MD for the purpose of Treatment, Payment and Health Care Operations (TPO). I have received a copy of the Notice of Privacy Policies & Practices and understand that I have the right to review prior to signing this document.

I understand:
-Service to me may be conditioned upon my consent as evidence by my signature on this document.
-I have the right to request a restriction as to hoe my PHI is used or disclosed to carry out the TPO of the practice. Mary Louise Lenahan, MD is not required to agree to the restrictions that I may request. However if Mary Louise Lenahan, MD agrees to a restriction that I request, the restriction is binding on Mary Louise Lenahan, MD.
-I have the right to revoke this consent in writing at any time except to the extent that Mary Louise Lenahan, MD has already made disclosures in reliance upon my prior consent.
-My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan and a health care clearing house. This PHI relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Policies & Practices Describes:
-The types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations performed by Mary Louise Lenahan, MD.
-My rights and the duties of Mary Louise Lenahan, MD with respect to my PHI.

Notification
-With my consent, Mary Louise Lenahan, MD may call my home or other designated location, including those listed on my demographic page and leave a message on voice mail or in person in reference to any items such as appointment reminders, insurance information and information pertaining to my clinical care.
Any restrictions on this are listed below:

_____

_____

_____

Additional persons authorized to receive PHI:

Name of Person/Organization & Relation: _____

Name of Person/Organization & Relation: _____

I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my health care and/or payment for my health care provided by Mary Louise Lenahan, MD.

Potential for Re-Disclosure:
-The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under federal privacy regulations.

Signature of Patient/Legal Guardian: _____

Name of Patient (Print or Type)
Relationship to Patient: _____

Date: _____