Print Form

KANER MEDICAL GROUP, P.A.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Kaner Medical Group to use and/or disclose certain protected health information (PHI) about me to:

NAME: RELATIONSHIP:

_____ _____

_____ _____

_____ _____

I do not have to sign this authorization in order to receive treatment form Kaner Medical Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy officer at:

KANER MEDICAL GROUP, P.A., 1305 Airport Freeway, Suite 220, Bedford, TX, 76021

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLIES):

☐ 1ST Telephone # _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ 2nd Telephone # _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number Only

☐ Written Communication

- ☐ OK to mail to my home address
- ☐ OK to fax to this #_____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Print Legal Guardian's Name & Relationship