Lifeline Medical Associates

Transforming Women's Healthcare

www.LMA-LLC.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

By signing this authorization, I authorize Lifeline Medical Associates, LLC to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Lifeline Medical Associates, LLC to use and/or disclose the following protected health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____.

(Expiration Date or Defined Event)

I understand and agree that either I or the appropriate third party, are financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is one dollar ($1.00) per page, with a maximum charge of one hundred dollars ($100.00) and an additional charge of ten dollars ($10.00) if records need to be retrieved from storage or microfilm.

I do not have to sign this authorization in order to receive treatment from Lifeline Medical Associates, LLC. 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 redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing at any time 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 99 Cherry Hill Road, Suite 220, Parsippany, New Jersey 07054.

Signed by: _____ Date: _____

Signature of Patient or Legal Guardian

Print Name: _____ Relationship to Patient: _____

Print Name of Patient or Legal Guardian