

DELAWARE FAMILY CARE ASSOCIATES
2700 Silverside Road, Suite 2
Wilmington, DE 19810
302-478-8421

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff to (check all that apply):

_____ use the following protected health information, and /or

_____ disclose the following protected health information to: _____

****Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.****

This protected health information is being used or disclosed for the following purpose:

****List specific purposes on the space provided below. "At the request of the individual is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose****

This authorization shall be in force and effect until _____, at which time this authorization to use or disclose this protected health information expires. ("End of the research study" and "none" is acceptable for authorization for research purposes.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 2700 Silverside Road, Suite 2, Wilmington, DE 19810. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority