AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized United Integrated Healthcare Center to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize United Integrated Healthcare Center to use and disclose the following information:

____ My Name, Address, Email and Phone Numbers
____ The Name of my Physician and the Clinic where I was treated

NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Address of Patient: _____ Phone: _____
(STREET)

_____ Email: _____
(CITY, STATE, ZIP CODE)

United Integrated Healthcare Center fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA , this authorization allows us to access only the above authorized information for contact purposes. Failure to sign this authorization will not affect you treatment, payment or eligibility for benefits in any way.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to United Integrated Healthcare Center. In this case, every effort will be made to discontinue future communications.

_____ _____
Signature (PATIENT OR PERSON AUTHORIZED) Date