Patient Authorization Form

Patient Name: _____ Birth Date: ____/____/____
MM / DD / YR

Address: _____

_____

Phone Home: _____ ____

Patient Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information in the manner described below. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide meaningful description, including treatment dates.)

	Demographics		Health Insurance information, i.e., identifying # or symbol		Conduct or behavior Relative to illness
	Diagnosis		Visit Dates		
	Treatment Plans		Domestic Difficulties		
	Financial Position		Home conditions		

2. Persons/Organizations Authorized to Use and/or Disclose My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), including **KAERBEAR'S HEALTHCARE SERVICES, LLC** to use and/or disclose the health information described above in Section 1 of this form.

	Kaerbear's Employees		DME Company		Laboratories
	Physician		Pharmacy		
	Contracted Services		Mobile Lab or X-Ray providers		

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

	Palmetto GBA		Florida PRO		
	Florida Medicaid				
	Other				

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

	Reimbursement				
	Agency Operations				
	Provision of services DME, etc.				

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact **Karen McGrath @ 305-940-6208.** I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Inspect or Copy the Health Information to Be Used or Disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed in accordance with this form. I may arrange to inspect my health information or obtain copies of my health information by contacting **Karen McGrath @ 305-940-6208.**

5.3 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Disclosure of Direct or Indirect Remuneration Received By Any Person or Organization Authorized to Use or Disclose My Health Information. I understand that the following person(s) and/or organizations(s):

: Will not be receiving any direct or indirect remuneration in connection with the use or disclosure of my health information.

7. Expiration of Authorization. This authorization will expire (choose and complete one):
_____/_____/_____. Date

Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 3 of this form:

_____

_____

_____

I, _____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Patient Signature Date

If Patient is unable to sign, complete the following:
Patient is unable to sign because: _____

_____