STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information listed below will be used or disclosed by Joel P Karasek MD PC

Information to be Used or Disclosed
The information covered by this authorization includes:
____Any Medical Information
____Mental Health Information

Persons to Whom Information may be Disclosed
Please Mark
____My insurance company
____Any doctor or care facility involved with the care of my child/children
____ Other (Name or Organization): ___________________________________
____ Other (Name or Organization): ___________________________________
____ Other (Name or Organization): ___________________________________

Any Person(s) or Organization You Do NOT Authorize to Receive Information:

____

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Expiration Date of Authorization:
This authorization is effective in perpetuity unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization:
You may revoke to terminate this authorization by submitting a written revocation to Dr Joel P Karasek MD PC.

Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation.

Name of Patient(s):
____

____

Signature of Parent or Patient Representative ____

Relationship:____ Date:__________________