HealthFirst
Family Care Center, Inc.

Print Name ______________________________

Date of Birth ________________________

INDIVIDUAL AUTHORIZATION

Authorization for Use and Disclosure of Individually Identifiable Health Information Other than for Treatment, Payment, and/or Healthcare Operations

I understand that, as a part of my healthcare, HealthFirst Family Care Center, Inc. receives, originates, maintains, discloses and uses individually identifiable health information including, but not limited to: health records and other health information describing my health history, symptoms, examination and test results; diagnoses; treatment; treatment plans; and, billing and health insurance information. I understand that HealthFirst Family Care Center, Inc. and its physicians, other healthcare professionals and staff may use this information for the following purposes:

- Diagnose my medical/psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals concerning my care
- Document services for payment/reimbursement
- Conduct routine healthcare operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I have previously consented to the use and disclosure of my individually identifiable health information for treatment, payment, and healthcare operations without restriction.

I understand that for all other uses and disclosures, except those that do not require consent, authorization or opportunity to object, I must sign an individual authorization for such uses or disclosures.

I also understand that if HealthFirst Family Care Center, Inc. is requesting authorization for its own use, it will not condition the treatment, payment and enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use or disclosure.

I understand that I may inspect or copy the individually identifiable health information or protected health information (“PHI”) to be used or disclosed. I further understand that I may refuse to sign the authorization.

If this disclosure will result in direct or indirect payment to the entity from an insurance company, I must receive a statement that such remuneration will result.

I hereby knowingly and voluntarily authorize HealthFirst Family Care Center, Inc. to disclose information to the types of agencies listed on the Notice of Information Practices.

This authorization expires one year from the date of the signature below.

I understand that I have the right to revoke this authorization in writing unless either of the following conditions exists:

- HealthFirst Family Care Center, Inc. has taken action in reliance thereon
- This authorization was obtained as a condition of obtaining insurance, and a law provides the insurer the right to contest a claim under the policy

I understand that I must deliver a written revocation to HealthFirst Family Care Center, Inc. and also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

______________________________ ______________________________
Signature of the individual Date

______________________________ ______________________________
Signature of witness Date

If a personal representative signs the authorization, a description of the representative’s authority to act follows:

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