Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

Medical records including diagnostic x-rays and studies, financial information necessary to process claims and receive payment, insurance records

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Dr. Joel D. Duchon
Name of person/organization

N/A
Name of person/organization

Expiration Date of Authorization
This authorization is effective through 12/31/2015 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

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 regulations.

The use or disclosure requested under this authorization will (will not) result in direct or indirect remuneration to this office.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.
I have read the above and hereby authorize Dr. Joel D. Duchon to use my protected information for listed reasons.

Signature

Name of Patient (print)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative

Office Representative Date