

RUDOLPH J. MOREIRA, M.D., INC.
STANDARD AUTHORIZATION OF USE & DISCLOSURE OF
PROTECTED HEALTH INFORMATION

INFORMATION TO BE USED OR DISCLOSED-THE INFORMATION COVERED BY THIS AUTHORIZATION INCLUDES: THE MEDICAL RECORDS WHICH ARE REASONABLY NECESSARY FOR A PARTICULAR PURPOSE, GIVEN THE CHARACTERISTICS OF THEIR BUSINESS AND WORKFORCE, THIS INCLUDES INSURANCE COMPANIES, HOSPITALS, OTHER PHYSICIAN OFFICES, ETC., AS REQUIRED TO PROVIDE THE MEDICAL CARE YOU ARE SEEKING AND BILLING PROCEDURES PERFORMED ON YOUR BEHALF TO YOUR INSURANCE COMPANY OR SELF.

PERSONS AUTHORIZED TO USE OR DISCLOSE YOUR INFORMATION-INFORMATION LISTED ABOVE WILL BE USED OR DISCLOSED BY: RUDOLPH J. MOREIRA, M.D., INC.

PERSON TO WHOM YOUR INFORMATION MAY BE DISCLOSED-INFORMATION DESCRIBED ABOVE MAY BE DISCLOSED TO: (ASSIGN ONE PERSON TO WHOM YOUR MEDICAL INFORMATION MAY BE DISCLOSED TO IN THE EVENT YOU ARE NOT ABLE TO RECEIVE YOURSELF)

NAME OF PERSON

RELATIONSHIP TO PATIENT

ADDRESS OF ASSIGNED PERSON

PHONE NUMBERS OF ASSIGNED PERSON

PLEASE STATE: MARK ONE OF THE FOLLOWING

_____ CONDITIONAL = YOU MAY ONLY SHARE MY INFORMATION WITH THIS PERSON IN THE EVENT I AM NOT CAPABLE OF SPEAKING FOR MYSELF.

_____ UNCONDITIONAL = YOU MAY SHARE MY INFORMATION WITH THIS PERSON REGARDLESS OF MY PHYSICAL OR MENTAL STATE WITHOUT ANY RESTRICTIONS WHATSOEVER.

THIS AUTHORIZATION IS EFFECTIVE UNLESS REVOKED OR TERMINATED BY THE PATIENT OR THE PATIENTS PERSONAL REPRESENTATIVE (power of attorney) IN WRITING. YOU HAVE THE RIGHT TO TERMINATE OR REVOKE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REVOCATION TO: RUDOLPH J. MOREIRA, M.D., INC. INFORMATION THAT IS DISCLOSED UNDER THIS AUTHORIZATION MAY BE DISCLOSED AGAIN BY THE PERSON OR ORGANIZATION TO WHICH IT IS HELD. THE PRIVACY OF THIS INFORMATION MAY NOT BE PROTECTED UNDER THE FEDERAL PRIVACY REGULATIONS.

NAME OF PATIENT-PRINTED

PATIENT SIGNATURE

DATE

NAME & RELATIONSHIP OF PATIENT REPRESENTATIVE
PRINTED

SIGNATURE OF REPRESENTATIVE

DATE