



Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Elizabeth Bonefas, M.D., P.A.

Information to Be Used or Disclosed

Information to be obtained under this authorization includes:

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person/organization

Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person/organization

Name of person/organization

Expiration Date of Authorization

This authorization is effective through __/__/__ 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 **Elizabeth Bonefas, M.D., P.A.** You should contact the **Privacy Officer, Frances Schock** to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.



Effect of Refusing Authorization

If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposes of treatment, payment, or supporting the day-to-day operations of the practice.

If you refuse to sign this authorization you may not be eligible for or receive research-related treatment or treatment that you have requested for the purpose of disclosure to others including:

Treatment conditioned on authorization

Treatment conditioned on authorization

Treatment conditioned on authorization

Signature

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient