AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Raynon A. Andrews, M.D., P.C.

I, ___________________________, hereby authorize **Raynon A. Andrews, M.D., PC** to use and/or disclose the following protected health information to (Name of Entity to receive information):
Specifically describe the information to be used or disclosed.

This protected health information is being used and/or disclosed for the following purpose(s):
Provide a description of the purpose of each use and disclosure.

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1. Complete if the authorization is for marketing purposes:
The use or disclosure requested under this authorization __ will __ will not result in direct or indirect remuneration to **Raynon A. Andrews, M.D., P.C**. from a third party.

2. Check one of the following statements below:
__ I understand that **Raynon A. Andrews, M.D., P.C.,** may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

__ I understand that if I do not sign this form, **Raynon A. Andrews, M.D., P.C.,** may not provide services to me because protected health information is solely being created for use and/or disclosure to: (*Name of Entity to receive information*).

This authorization shall be in force and effect until Date:____________________or Event:______________________ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Raynon A. Andrews, M.D., P.C.,** at **1878 Jeff Rd, Suite A Huntsville, AL 35806.** I understand that a revocation is not effective to the extent that **Raynon A. Andrews, M.D., P.C.** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

______________________________	______________________________
Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
______________________________	______________________________
Date	Relationship to Patient (or other authority to serve)