GOOD HEALTH ASSOCIATES, PLLC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Good Health Associates, PLLC to use and/or disclose or to receive certain protected health information (PHI) about me to/from _____ located at _____
Name of entity to receive or send this information
_____. Other entities should send records to Good Health Associates, PLLC, 625 N. Highland Ave., Murfreesboro TN 37130. This authorization permits Good Health Associates, PLLC to use and/or disclose the following individually identifiable health information about me:

My entire medical record with the exception of the item(s) checked below:

- □ Substance abuse, if any
- □ Psychological or psychiatric conditions, if any
- □ AIDS/HIV, if any
- □ Other: _____
  _____

The purpose of this request is "at the request of the individual," unless otherwise stated. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will *expire ninety days from* the date of signature below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Good Health Associates, PLLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 625 N. Highland Ave., Murfreesboro, TN 37130.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Patient's Date of Birth6

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION