1-888-CARMEL-2
(227-6352)
www.carmelcare.net

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____ , the undersigned, authorize the use and/or disclosure of my Protected Health Information ("PHI") as described below. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on the signing of this authorization.

1. **Patient Information**

   Name: ____ Date of Birth: ______________

   Address:____

   City: ____________________________ State: ___________ Zip: ______________

   Telephone: ____________________________ Social Security No: ______________

2. **Person/Office Authorized to Disclose PHI ("Sender")**:

   ◻ Other: Name:____

   Address:____

   City: ____________________________ State: ___________ Zip: ______________

   ◻ Carmel Care PLLC (the service of Gary L. Berlin, M.D.)

3. **Person/Office Authorized to Receive PHI ("Receiver")**:

   ◻ Carmel Care PLLC (the service of Gary L. Berlin, M.D.)
   ◻ Other: Name: ____

   Address: ____

   City: ____________________________ State: ___________ Zip: ______________

4. **Description of PHI to be Disclosed**: (entire medical record, lab/x-ray reports, etc.):

   ◻ Entire medical record ◻ Other (reports, dates of service, etc.): ______________

5. **Expiration Date/Event:** This authorization will expire:

   ◻ Upon completion of the requested disclosure ◻ In one year from today

This authorization shall become effective immediately. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that it has already been relied upon. I further understand that when my PHI is disclosed pursuant to this authorization, it may be subject to re-disclosure by the person(s) authorized to receive my PHI. A photocopy, scan, or any other digitized version of this signed original shall be deemed to be, and should be accepted as, an original.

Signature of Patient or Representative: ___________________________ Date: _______________

Printed Name: _______________________________ Relationship to Patient: _______________