ASHEVILLE INTEGRATIVE MEDICINE

James Biddle, M.D.

Authorization to Use or Disclose Protected Health Information

I, _____, authorize Asheville Integrative Medicine to disclose my protected health information as described on this form to the recipients listed below. I understand that when the 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 health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below. I understand Asheville Integrative Medicine is otherwise not authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or healthcare operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's full medical records

[ ] Only Specific Medical Data/Information as : (Please Check)
- [ ] Condition(s): _____
- [ ] Medication(s): _____
- [ ] Other: _____

Name(s) of person(s) authorized by this form who may use and disclose the patient's protected health information other than AIM (such as family members):

_____

_____

_____

This authorization **shall/shall not** expire (please circle and/or enter date) _____After this date, if one is entered, Asheville Integrative Medicine can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

The patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

I fully understand and accept the terms of this authorization.

_____ _____

Patient's Signature Date

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