

Erin L. Koster MD, PA

Standard Authorization of Use and Disclosure of Protected Health Information

The information covered by this authorization should include:

___ ALL information in my file (includes demographics, reports, labs, and any other information obtained)

___ ONLY: _____

The information described above may be disclosed to:

Name of person/organization

Name of person/organization

Name of person/organization

This authorization is effective unless and until revoked by the patient or the patient's personal representative.

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the Office Manager to terminate this authorization.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Patient:

-You may inspect or copy information used or disclosed under this authorization

-You may refuse to sign this authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others.

I understand that the information listed above will be disclosed by Erin L. Koster, M.D. P.A. for education, discussion of treatment plan, and/or medical decision making. By signing this document I am authorizing Erin L. Koster, M.D. P.A. to release my information to the organization(s)/person(s) listed above.

Name of Patient (Print)

Signature of Patient Date

Signature of Patient Representative (if applicable)
Relationship of Patient Representative to Patient: _____