Family Beginnings P.C.
Authorization to Use or Disclose Information

I herby authorize the use or disclosure of my individually identifiable health information as describe below. I understand this authorization is voluntary. I understand that if the organization or persons authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patients Name: _____

Patients Address:	

Persons/organization providing the information:
Family Beginnings P.C.

Persons/organization receiving the information:
Myself

- **Specific descriptions of information to be used or disclosed (including dates)**

All Medical Information

- **Reason for use or disclosure of information:**

To Give Patient Lab Results

The person or organization providing the information will /will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. (to be completed only if the authorization is for marketing purpose)

- I understand that I will not be denied health care or health plan coverage, as the case may be, if I do not sign this form.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that this authorization will expire 3yrs after I sign this form and will have to resign in 3yrs.
- I understand that I may revoke this authorization at any time by notifying the person or organization providing the information in writing, but if I do it will not affect any actions take before the revocations is received.

Sign _____ Date _____

Printed Name of Patient's Representative: _____

Relationship of Representative: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

FOR OFFICE USE ONLY

Revocation Date: _____

Processed By: _____

Signature: _____

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Patients Name: _____

Patients Address:	

Persons/organization providing the information:
Family Beginnings P.C.

Persons/organization receiving the information:
Husband, Parent, Significant other ect..

- **Specific descriptions of information to be used or disclosed (including dates)**

All Medical Information

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