

## Authorization for the Use and Disclosure of Individually Identifiable Health Information Without Conditions

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations within the covered entity authorized to use or make disclosure of the information: Jack R. Eades, M.D.; Employees of Southern Allergy & Asthma, P.C.
2. Persons/organizations authorized to receive the information: Group Health Plans, Health Insurance Issuers, Health Care Clearinghouses (which process information for insurance payments), Health Care Providers
3. Specific description of information that may be used/disclosed: Any information needed for treatment, payment or health care operations.
4. This authorization permits the use and disclosure of health care information for marketing purposes as described below. NO  YES
5. If the answer to 4 is YES, (Organization name) WILL  WILL NOT  receive remuneration from a third party for the use of this health care information.
6. The information will be used/disclosed for the following purposes (all purposes must be listed and described)  
Purpose 1 Evaluation and treatment of patient  
  
Purpose 2 Payment for treatment of patient
7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.
8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
  - a) [organization] has taken action in reliance on this authorization; or
  - b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
9. This authorization expires an (upon) \_\_\_\_\_ [INSERT APPLICABLE DATE OR EVENT]

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Printed name of patient or patient's representative

\_\_\_\_\_  
Relationship to the patient or  
Authority to act for the patient

\_\_\_\_\_  
Date

{If the above signature is that of a patient's representative, (organization) must complete the following.}  
(Name of organization) has verified the identity of (patient's representatives name) by (describe means of verification. e.g.; driver's license) and that in his/her capacity of (description of authority to act e.g., husband, wife, etc.) He/she is authorized to act on behalf of the patient.