Massage Doctor

MASSAGE DOCTOR PLLC
Dr. Abdul Karim Taifour, LMPC
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AUTHORIZATION TO RELEASE & SHARE INFORMATION

Name _____ Date of birth ____/____/____
first middle initial last *month day year*

Address _____
street address apt # city state zip code

I give permission to **Abdul Karim Taifour, LMPC, dba Massage Doctor PLLC,** to share my health information as identified below, with:

Person _____

Company / Organization _____

Address _____

Phone _____ Fax _____

☐ All of my health information that the provider has
☐ All of my health information that the provider has covering a certain period of time:
from: _____ to: _____
☐ All of my health information that the provider has relating to a certain event or injury:
event or injury: _____which occurred on date:_____
☐ My health information regarding AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus)
☐ My health information regarding mental/behavioral health services or psychiatric care
☐ My health information regarding treatment for alcohol and/or substance abuse
☐ Other: _____

Purpose: The provider may exchange the health information it has for me, for this purpose:
☐ For billing and payment purposes
☐ To coordinate care and treatment
☐ For a research study
☐ For marketing purposes
☐ Other: _____

Term of Authorization: The provider may share my health information from the date of this Authorization until I revoke it in writing. Per HIPPA regulations, I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may be charged a processing fee by either party for this service. I understand I may revoke this authorization at any time in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature: _____Date: _____

Signature of Guardian/Representative: _____ Date: _____
Relationship of Personal Representative: _____