

**Bay Area Oriental Family Practice, P.A.**

**AUTHORIZATION FORM  
FOR OTHER USES OF PROTECTED HEALTH INFORMATION (PHI)**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose:

---

---

---

Individuals who may use or disclose this information: \_\_\_\_\_

---

Individuals who may receive and use the disclosed information: \_\_\_\_\_

---

Expiration date of this authorization: \_\_\_\_\_

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by: \_\_\_\_\_

Printed Name - Patient or Representative

In front of \_\_\_\_\_

Printed name - Practice representative

Witness: \_\_\_\_\_ / /

Name

Date

By: \_\_\_\_\_

Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_