Patient Authorization For Practice to
Release Protected Health Information
to Third Parties

By signing this authorization, I authorize Advent Health Group, P.C. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Advent Health Group, P.C./Dr.Natividad to use or disclose to:

Name of person(s)	**Relation to me**	**Specify disclosure(s)**

The following individually identifiable health information: test results; social, mental & physical health; appointment information; billing (and/or billing related account information); complete history and physical information; social, mental, physical, demographic information, etc. If you would like us to disclose complete information from your medical records, then please write "***complete***" under the disclosure column.

_____ I give authorization to allow verbal messages with contact name and telephone number(s) on recording devices connected to patient telephone system. (Initial to allow such messages)

This authorization will expire on _____. (write "***indefinite***" if no end date applies).

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer protected by the federal HIPAA Privacy Rule.

By signing this form, I am consenting to Advent Health Group,P.C./Dr. Natividad use and disclosure of my PHI to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advent Health Group,P.C./Dr. Natividad may decline to provide treatment to me.

_____ _____ _____

Print name of patient/guardian signature date