ADD LIFE Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Fred W. Stelson, M.D., sole proprietorship doing business as ADD LIFE Center, to use and/or disclose certain protected health information ("PHI") about me to ____.

This authorization permits Aligned to use and/or disclose the following individually identifiable health information about me: ____
____

The information will be used or disclosed for the following purpose:

1. at the request of the individual
2. payment for services

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ____________________________.

Aligned will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Aligned. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: info@addlifecenter.com

Signature ____

Printed Name ____________________________________

Date________________________________