Bay State Health Center

Health Care Authorization Form

Patient Name: _____ S.S.#: _____ DOB: _____

The patient identified above authorizes the Bay State Health Center to use and / or disclose protected health information in accordance with the following:

SPECIFIC AUTHORIZATIONS

☐ I give permission to the Bay State Health Center to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives and other health related information.

☐ If the Bay State Health Center contacts me by telephone, I give them permission to leave a telephone message on my answering machine or voice mail.

☐ **OPEN ROOM AUTHORIZATION – OPTIONAL**.....I give the Bay State Health Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with the doctor at any time in private, the doctor will provide a private setting for these conversations.

☐ By signing this form you are giving the Bay State Health Center permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

This authorization shall be in force for the duration of my relationship with the Bay State Health Center.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of the Bay State Health Center. The written notice must contain the following information: **Your name, social security number and date of birth; A clear statement of your intent to revoke this authorization; The date of your request;** Your **signature.** The revocation does not become effective until it is received by the Privacy Official.

This authorization is requested by the Bay State Health Center for its own use / disclosure of protected health information *(minimum necessary standards apply)*. You have the right to a copy of the protected health information to be disclosed. A copy of this signed authorization will be provided to you upon request.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, the Bay State Health Center will not refuse to provide treatment.

Print name of patient	Signature of patient	Date

Signature of Personal Representative & Description of Representative's Authority to Act on Behalf of Patient