AUTHORIZATION FOR USE/DISCLOSURE OF PHI REQUESTED BY EAST TEXAS PROSTHETIC ORTHOTIC CARE

I, _____ hereby authorize **ETPOC** to (check those that apply):

X use the following protected health information, and/or

X disclose the following protected health information to ETPOC:

MEDICAL RECORDS

This protected health information is being used or disclosed for the following purposes:

TO VERIFY NEED FOR PRESCRIBED SERVICES AND PROOF OF MEDICAL NECESSITY FOR FUNDING SOURCE AND/OR INSURANCE COMPANY IN ORDER TO SECURE PAYMENT FOR SERVICES RENDERED

This authorization shall be in force and effect while under the care of ETPOC. Termination of this authorization to use or disclose protected health information must be submitted in writing as described below.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Cynthia A. Wright at 812 N. 4th Street, Longview, TX 75601. I understand that a revocation is not effective to the extent that ETPOC must utilize protected health information in order to secure payment for services previously rendered and/or in compliance on the part of ETPOC in cases of mandatory legal disclosure or subpoena.

I understand that I have the right to:

*** Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

*** Refuse to sign this authorization

*** ETPOC will not condition my treatment on whether I provide authorization for the requested use or disclosure, **except under the following circumstances**:

1) When the provision of appropriate health care by ETPOC requires detailed patient medical history that will influence or impact proposed treatment and services, and 2) insurance verification, prior authorization, and/or pre-certification, and/or purchase orders leading to reimbursement for services to be rendered is dependent and contingent upon my authorization to collect and/or disclose protected health information to one or more third parties.

*** **The use of disclosed protected health information under this authorization will result in direct or indirect remuneration to ETPOC from a third party.**

Signature of Patient or Personal Representative	**Name of Patient or Personal Representative**
Date of Birth	**Date**
	Description of Personal Representative's Authority