EMP
Emergency Medicine Physicians

EPMG
Emergency Physicians' Medical Group, Inc.

HMG
Hospitalist Management Group

MBFS
4535 Dressler Rd. NW, Canton, OH 44718
1-800-982-8177 Fax (330) 492-8489

MBFS Use Only

IDXMRN ____________

Facility ____________

Date Received: ____________

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
45 CFR 164.508(c)

1. I authorize my health care provider and his/her medical billing company, Medical Billing and Financial Services, Ltd. (MBFS), to use and/or disclose the medical and billing information about me described below.

2. My health care provider and MBFS are authorized to disclose my health information to the following individual(s) and/or organizations such as carriers, insurance companies, law firms, etc.: (Must fill out)

   ____

   ____

3. I would like my health information disclosed for the following reason(s): ____________________

   ____

4. The information that may be used and/or disclosed is: (Must check one)

   _____ Any and all medical and billing records concerning all medical care that I have ever received from my health care provider
   _____ Any and all medical and billing records concerning medical care I received from my health care provider on: ____________
   _____ Other: ____________________

5. The following items must also be checked to be included in the use and/or disclosure of health information pursuant to this Authorization:

   _____ (a) HIV/AIDS related information and/or records
   _____ (b) Mental health information and/or records
   _____ (c) Genetic testing information and/or records
   _____ (d) Drug/alcohol diagnosis, treatment and referral information

6. I understand that if a person or entity that receives information pursuant to this Authorization is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release EMP therefore, I release my health care provider, his/her employer and MBFS from all liability arising from this disclosure of my health information.

7. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Privacy Officer at 4535 Dressler Road, N.W., Canton, OH 44718. I understand that a revocation is not effective to the extent that my health care provider and MBFS have already taken action in reliance upon this Authorization.

8. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

9. This Authorization will expire six (6) years from the date signed below, or ____________________, whichever is earlier.

____
Patient's Name (Please Print)

____

____
Address of Patient

Social Security No.: ____________

Account No.: ____________

____
Signature of Patient

Date: ____________

____
Name of Patient's Personal Representative/Guardian, If Applicable (Please Print)

____

____
Address of Personal Representative/Guardian

____
Description of Representative's Authority to act for the Patient

____
Signature of Personal Representative/Guardian

Date: ____________

Effective 04/14/03
Revised 04/04/06
Revised 03/29/07