MP VEERA MD PA

YOUR AUTHORIZATION TO COMMUNICATE FORM

As stated in the HIPAA privacy laws, this authorization form permits MP VEERA MD PA to use or disclose protected health information listed in the **Description Section** to the Entity or Person listed in the **Receiving Entity section** below for the following patient/you:

Name ________________________________ Birth Date _______________
Address ____
City/State/ Zip ____

Description of information to be given to checked Entity or Person.	Receiving Entity or Person Please check & list carefully
☐ Appointment or absentee from work information/form ☐ Return to work or school information/form	Employer _________________________ School _________________________
☐ Family billing information ☐ Financial information ☐ Medical –pl. list or mark as “ALL” _________________________________ _________________________________	Spouse (Provide full name) ___________________________ ___________________________
☐ Family billing information ☐ Financial information ☐ Medical -pl. list or mark as “ALL” _________________________________ _________________________________	Parent(s) (Provide full name) ___________________________ ___________________________ ___________________________ ___________________________
☐ Family billing information ☐ Financial information ☐ Medical -pl. list or mark as “ALL” _________________________________ _________________________________	Other (Provide full name) ___________________________ ___________________________ ___________________________ ___________________________

Purpose

The purpose of this authorization is to meet your request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or _______________ date is the specific end date of this authorization.

Verification method or code: This practice will verify the identity of any entity or individual requesting protected health information by asking the your full name, date of birth and may request for the last four digits of your social security #

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to MP VEERA MD PA, 130 Perpetual Square Dr., Anderson, SC 29621 Attn: HIPAA Officer. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

____Date _____________

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

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Office Use Only (Employee please sign, scan and give back this original to patient):

Employee ___________________________Date received ______

- ☐ **Copy given to patient by receiving employee**