PRESIDENTIAL HEALTHCARE CENTER

5215 LOUGHBORO ROAD NW
PRESIDENTIAL SUITE 470
WASHINGTON, DC 20016

Patient Authorization for Specified Use and Disclosure of Protected Health Information

By signing, I, ____authorize the Presidential Healthcare Center and Dr. Jeffrey A. Elting, M.D., M.P.H., M.S. to use and/or disclose certain protected health information (PHI) about me to:

Name of other medical practice or individual: ____________________________________

Address:__________________________

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Telephone: _______________ Cell:________________Email: _____________________

This authorization permits the Presidential Healthcare Center and Dr. Jeffrey A. Elting, M.D., M.P.H., M.S to use and/or disclose the following individually identifiable health information about me. If there are limitations, specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.). Otherwise all PHI will be presumed cleared for release:

____

The information will be used or disclosed for the following purpose (please specify):

____

This authorization will be indefinite or otherwise expire on _________________.

The Practice will ___ will not _x__ 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 Dr. Jeffrey A. Elting, M.D., M.P.H., M.S. 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 5215 Loughboro Road NW Suite 470 Washington, DC 20016, 202-537-1100, 202-537-1101 Fax.

______________________________________ _____________________
Signature of Patient or Legal Guardian Date Relationship to Patient

_____________________________ Print Name of Parent or Legal Guardian