AUTHORIZATION TO DISCLOSE INFORMATION/RECEIPT OF PRIVACY PRACTICES

Effective Date: _____

The Notice of Privacy Practices tells you that TransSouth Health Care, PLLC. may use or disclose information about you. Not all situations are described. TSHC is required to give you a notice of our privacy practices for the information we collect and keep about you. **PLEASE REVIEW THE NOTICE CAREFULLY.**

I, _____, have been given a copy of TRANSSOUTH HEALTH CARE's Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as examining you to create a report for your attorney). WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.

THIS AUTHORIZATION IS VOLUNTARY

By my request, I hereby authorize TRANSSOUTH HEALTH CARE, P.C. to disclose information regarding my treatment, insurance issues and payment issues to the people listed below:

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan., health care provider, or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulations. I understand that I may withdraw my authorization in writing to the Privacy Officer of TRANSSOUTH HEALTH CARE, PLLC. at any time, except to the extent that action has been taken in reliance on this statement. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

Patient Signature or Representative _____Date_____