PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Paul Rottler, M.D., PC to use and/or disclose protected health information (PHI), (my entire medical chart), about me to or for the party or parties listed below.

This authorization permits Paul Rottler, M.D., PC to use and/or disclose to:

Name of person to disclose information to	Relationship to Patient	Phone Number

This information will be used or disclosed at the request of the individual patient.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 Office at 13625 Big Bend Road, St. Louis, MO 63122.

Signed: _____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian

_____
Patient's Name

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION