Joy B. Chastain, M.D., F.A.A.D.
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Patient Authorization for Practice to Release Protected Health Information

Joy B. Chastain, M.D., P.C. requires all patients to complete this form to indicate patient authorization to use and/or disclose certain protected health information (PHI) to the party or parties listed below in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law.

Patient Name: _____ Date of Birth: _____
(Last) (First)

I authorize all Joy B. Chastain, M.D., P.C. staff to use or disclose to the following individual(s):

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

The listed individual(s) may receive all protected health information. If you would like to provide restrictions to this disclosure, please define those restrictions below:

_____

_____

_____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information 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 Joy B. Chastain, M.D., P.C. has acted in reliance upon this authorization. My written revocation must be submitted to the Practice Manager.

_____ _____
Signature of Patient / Parent / Guardian / Legal Representative Date

_____ _____
Printed Name of Parent / Guardian / Legal Representative Relationship to Patient

Authority to Sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney of Healthcare
☐ Other As Specified: _____