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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: MARKETING

DISCLAIMER

This document is provided solely for informational purposes and to assist the typical physician practice which must undertake reasonable measures to comply with HIPAA Rules. While the document has been drafted to provide accurate and authoritative assistance, it is not intended as, and does not constitute legal or other professional advice, which can be rendered only on an individual practice and fact-sensitive basis. The information in it is not guaranteed to be correct, complete or up-to-date. Each practice must review this document for individualized adaptation to your practice or to a particular transaction. Readers should not act or elect not to act based upon the provided information without seeking professional legal advice from healthcare counsel.

[PRACTICE NAME]
Authorization for Use and Disclosure of Protected Health Information: Marketing

This form provides authorization to **[PRACTICE NAME]** ("the Practice") to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____, (date of birth: _____) authorize the Practice to (choose one): disclose to / obtain from:

_____

With an address at: _____

_____

_____

The following information:

_____

_____

_____

The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization.

I understand that if my records contain information about alcohol and drug abuse, mental health treatment, and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record only if I place my initials on the appropriate line as set forth below.

Included in information to be released:
____ Alcohol/Drug Treatment
____ Mental Health Information
____ HIV Related Information

Purpose of Information to be Disclosed: Marketing
Marketing is a communication about a product or service that encourages purchase of the product or service. Marketing specifically excludes; refill reminders for prescribed medications (so long as there is no remuneration in excess of the reasonable cost of making such communications), and certain other communications for treatment and health care operations purposes where there is no remuneration to the practice in exchange for making such communications.

I understand that the Practice will receive financial remuneration from a third party as a result of this marketing.

This authorization shall expire upon the earlier of (i) ____ days from the date of this request or (ii) the following date _____ or (iii) the occurrence of the following:
_____.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer at **[PRACTICE NAME AND ADDRESS]**.
I understand that a revocation is not effective to the extent that the Practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority