CareNow®

Patient Authorization for Disclosure of Protected Health Information via E-Mail

Please print all information, then sign and date authorization form at bottom.

Patient Name: _____

Practice Name: _____

Social Security Number _____ Patient Date of Birth _____

Purpose of request - I authorize CareNow to disclose or provide protected health information (as described below) directly to me at the e-mail address I have indicated. I understand that it is my responsibility to notify CareNow of any change in my e-mail address and that any disclosure made to the e-mail address, indicated by me, is subject to the redisclosure statement within this authorization.

E-Mail Address: _____

Description of information to be disclosed - I authorize CareNow to disclose the following protected health information about me to the e-mail address I have indicated *(please provide a written description of the information to be disclosed, such as results of exams, laboratory tests, procedures, and other healthcare services)*:

_____

_____

_____

_____

_____

Purpose of disclosure – I am authorizing the disclosure of my protected health information the specified e-mail address as a means of enhancing communication with my healthcare provider and the practice.

Expirations or termination of authorization – This authorization will expire at the end of the calendar year in which it was initiated, unless I specify an earlier termination. I understand that I must submit a new authorization after the expiration date to continue the authorization. I also understand that I have the right to terminate this authorization at any time.

(Please list desired expiration date):_____

Right to revoke or terminate – As stated in our Notice of Privacy Practices, I have the right to revoke or terminate this authorization, except to the extent that we have taken an action in reliance to the authorization prior to your termination. You may terminate this authorization by submitting a written request to our Privacy Manager.

Re-disclosure – I understand that the practice has no control regarding persons who may have access to the e-mail address I have listed to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Non Conditioning – There is no restriction of your treatment as a condition for signing this authorization.

_____ _____

Patient or Guardian Signature **Date**

Copies of signed authorizations available upon request.

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Referenced from Eagle Associates 7.34