HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320D, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

Trinity Doctors Group, ("Covered Entity") will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Covered Entity may use or disclose medical information for the purpose(s) of continuity of care and billing.

By signing this authorization you agree that Covered Entity or its Business Associates may disclose your personal health care information to intended recipients.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at the office or by sending a written request with return address to 8215 State Road 54, New Port Richey, FL 34655.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy you PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, expected to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Covered Entity will provide a copy of this signed authorization when requested.

Trinity Doctors Group, P.A. may release my Protected Health Information to:

Name/Relationship/Phone: _____/_____/_____

Name/Relationship/Phone: _____/_____/_____

☐ Trinity Doctors Group, P.A. may call my home or cell and leave a message on voicemail or in person in reference to any item that assist the clinic in carrying out healthcare operations, appointment reminders, insurance information and calls pertaining to clinical care, such as laboratory results.

Acknowledged and agreed to by:

_____

Patient (or Legal Guardian) Signature Date