AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEATLH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

   _____

   _____

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information.

   Ridge Medical Associates _____

   _____

3. I authorize the following persons (or class of persons) to receive my protected health information:

   _____

   _____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and addressed to my physician at this practice. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not effect my abilities to obtain treatment from Ridge Medical Associates, nor will it affect my eligibility for benefits.

8. My protected health information will by used or disclosed upon request for the following purposes:

   _____

   _____

I certified that I have received a copy of the authorization.

Signature:_____ Date:_____

Printed Name:_____