Elisabeth Huelskoetter, M.D., LLC

Authorization for Use and Disclosure of Protected Health Information

I,___________________________________, hereby authorize Elisabeth Huelskoetter, MD, LLC to use and/or disclose the following **protected health information (PHI),** via mail, telephone call or voicemail message, to:

____ Relationship__________________________
____ Relationship__________________________
____ Relationship__________________________

This PHI is being used for the following purposes:

Providing appointment reminders
Describing or recommending treatment alternatives
Providing information about health-related benefits and services that may be of interest to the individual
Soliciting funds to benefit the covered entity

I acknowledge that I have the opportunity to review the Privacy Notice prior to signing this consent. Elisabeth Huelskoetter, M.D., LLC also has the right to revise this Privacy Notice at anytime and will provide me with a revised Notice upon my request. I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested in this authorization will result in direct or indirect compensation to **Elisabeth Huelskoetter, M.D.** from a third party.

This authorization will remain in effect until further notice from patient or legal guardian of patient.

____ __________________________
Signature of Patient or Representative/Guardian Date

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Printed Name of Patient or Representative/Guardian