DW SIEVERT M.D., INC.

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Are there any restrictions on PHI to be disclosed? ❒ Yes ❒ No

_____No one other than myself may have access to my medical records:

May our office leave a message on your answering machine? ❒ Yes ❒ No

I consent to the use or disclosure of my protected health information by DW SIEVERT M.D., Inc. for the purposes of diagnosis of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DW SIEVERT M.D., Inc. I understand that diagnosis or treatment of me by DW SIEVERT M.D., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information (PHI) is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DW SIEVERT M.D., Inc. is not required to agree to the restrictions that I may request. However, if DW SIEVERT M.D., Inc. agrees to restriction that I request, the restriction is binding on DW SIEVERT M.D., Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that DW SIEVERT M.D., Inc. has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This PHI relates to my past, present or future physical or mental condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that the "Notice of Privacy Practices" describes how DW SIEVERT M.D., Inc. may disclose and use my protected health information (PHI). I am encouraged to read the "Notice of Privacy Practices" in full.

Signature: _____ Date: _____
(Patient Signature or Authorized Representative and relationship)

Printed Name: _____