Thomas E. Bowser, M.D., PLLC
Authorization to Use or Disclose Protected Health Information

I hereby authorize the use or disclosure of the named individual's information as described below:

Patient Name | Date of birth | Social Security Number

Address (street, city, state, zip code) | Telephone Number

The following individual or organization is authorized to make the disclosure:

_____ Thomas E. Bowser, M.D., PLLC

_____ Other (please specify) _____

Treatment Dates: | Purpose of Request:

The following information is to be disclose : (please check one for each item.)

Yes	No	physician notes
Yes	No	lab results
Yes	No	radiology reports
Yes	No	hospital records
Yes	No	other _____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information them may not be protected by the federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my Enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be use or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition (If I do not specify an expiration date, event or condition, this authorization will expire in 6 months.)

Signature of Patient or Legal Representative | Date

If Signed by Legal Representative, Relationship to Patient | Witness Signature