IMMUNOe HEALTH CENTERS
Excellence in Immune Health

HORIZON PEDIATRICS & PRIMARY CARE

Sinus Solutions AT IMMUNOe

Authorization to Use or Disclose My Health Information

Patient Full name: _____DOB: _____Leaving Practice? Y / N

☐ All my health information maintained by IMMUNOe Health Centers, Horizon Pediatrics & Primary Care & Sinus Solutions at IMMUNOe. ***Or Specifically (check all that apply):***

☐ All my health information except for the following treatments of conditions:_____
☐ All my health information except for information for the date(s): _____

I specifically authorize disclosure of the following conditions (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ HIV/AIDS ☐ STD's

☐ Behavioral Health Services/Psychiatric Care ☐ Genetic Counseling/Testing

☐ My health information to the following Provider/Organization"
Name: _____
Address: _____ City:_____ State:_____ Zip: _____

MY REVOCATION OF PRIOR AUTHORIZATION (check all that apply):

I understand that I have a right to revoke this and prior authorization at any time.

☐ At my request
☐ I revoke my Prior Authorization

MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:
To take part in a research study; OR To receive health care when the purpose is to create health information for a third party.
I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it. Pricing is $18.53 for the first 1-10 pages, $0.85 per page for pages 11-40, and $0.57 for each additional page thereafter. Flat fee for postage.
IMMUNOe Health Centers and Horizon Pediatrics Primary Care endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

_____ ____/____/____ _____
Patient or legally authorized individual signature **Date** **Time**

_____ _____
Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative, etc.)**