Barry Fernando, M.D.

Authorization for Use or Disclosure of Protected Healthcare Information

I authorize my physician and /or administrative and clinical staff to:

_____ Disclose protected information to the insurance company for payment.

_____ Disclose protected information to physicians you are referred to.

_____ Disclose protected information to Healthcare Operations for treatment.
(ie; Hospital, Laboratories, Anesthesia, etc).

I understand that I have the right to revoke this authorization, in writing, at anytime by sending such written notification to the practice's Privacy Contact at 2777 East Camelback Road #140 Phoenix, AZ 85016. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected information, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) healthcare services are provided to me, soley for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect renumeration to my physician from a third party.

Signature: ____ Date: ______________

Witness: ____