AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATORS

I hereby authorize the release or use of my initially identifiable health information ("protected health information") and medical information by DR. MICHAEL DAPAAH, P.A. in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for more complete descriptions of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of this Notice of Privacy Practices at any time. If we do make changes to the terms of this Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our Practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s) such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf.

_____

_____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

_____ HIV/AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ If patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the appropriate spaces below):

_____ Via e-mail to the Patients designated e-mail address which is: (I am responsible for notifying the Practice of any changes to my e-mail address.)

_____

_____ Via regular e-mail with any envelopes being marked personal and confidential and Addressed to me.

_____ Via telephone if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).

Via fax to my designated fax number which is: _____

At any time, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice is ready to take action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) does not sign the Consent Form. If you (or authorized representative) sign this Consent and then revokes, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in the consent, I have received a copy of the consent, and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Date _____ Time _____ AM/PM

_____

Signature of Patient for authorized representative

_____

Print Name

Please explain representative's relationship to the Patient and include a description of the representative's authority to act on behalf of the Patient:

_____

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