



Authorization for Use and Disclosure of Protected Health Information

I _____, hereby authorize, Dr. Catherine Holt to use and/or disclose the following **protected health information (PHI)** to:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

May we leave a voicemail regarding medical information? YES NO

This PHI is being used or disclosed for the following purposes:

- Provide appointment reminders*
- Describe or recommending treatment alternatives*
- Providing information about health-related benefits and services that may be of interest to the individual.*
- Soliciting funds to benefit the covered entity*

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested in this authorization will result in direct and indirect compensation to **Catherine Holt, M.D.** from a third party.

This authorization will remain in effect until further notice from patient or legal guardian of the patient.

Signature of the patient or representative/Guardian

Date

Print Name of Patient or Representative/Guardian