Authorization to Use or Disclose Protected Health Information

The Drugless Doctors

Name:	DOB:
Address:	Phone #:
City/State:	Zip:
Email:	Date of Request:

As required by the Privacy Regulations, The Drugless Doctors may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative *Date*

Authorized Signature of Facility *Date*

Include as much information as possible. If you do not have a response to a question, please indicate by writing “None”.

Age: _____

Gender: _____

Occupation: _____

Primary Care Physician: _____

Clinical Concerns: _____
_____
_____

Current Symptoms: _____
_____

Current Treatment: _____
_____

Current Medication(s): _____
_____

Thermogram History: _____
_____

Previous Report #'s: _____

Results of clinical correlation: _____

Mammogram/Ultrasound History: _____
_____

Family History: _____
_____

Ob/Gyn History: _____
_____

Surgical History: _____
_____

Dental History: _____
_____

General History: Diagnoses: _____
_____

Skin Lesions/ Physical Abnormalities: _____
_____

Notes:_____
_____
_____

Examples for Reference

HISTORY AND SUBJECTIVE COMPLAINTS

Age: (eg. 45)

Gender: *(eg,Fema/e)*

Occupation: *(eg, retired hairdresser)*

Primary Care Physician: *(eg, John Smith MD.)*

Clinical Concerns: *(eg, obesity and diet give concern for early diabetic change and DJD* of *both knees, blood sugar is in the high normal) or (None... establishing baseline)*

Current Symptoms: *(eg, intermittent stabbing pain in both knees for the last* 6 *months, aggravated by standing /walking, relieved by rest.) or (No symptoms)*

Current Treatment: *(eg, Physiotherapy and acupuncture when started, for how long, results, etc.)*

Current Medication: *(eg, Occasional Tylenol for pain) or (if generic drug name not known, class* of *drug is helpful: anti-hypertensive, anti-cholesterol, anti-diabetic, anti-inflammatory, etc)*

Thermogram History: *(eg,* 1*study 2005 for pain in left elbow) or (Baseline breast) or (annual breast, no changes reported) or (suspicious finding in left breast, recommended follow-up)*

Previous Report #'s: *(if known)*

Results of clinical correlation: *(eg, exam by PCP negative) or (Nurse found lump and referred patient to breast specialist) or (patient* has *not sought clinical opinion since last thermal exam)*

Mammogram/Ultrasound History: *(eg, no suspicious results) or (small calcifications UOQ left breast considered benign) (when, area/location, opinion, follow-up, recommendations, outcome)*

Family History: *(eg, cancer, heart, diabetic etc)*

Ob/Gyn History: *(eg, cervical cancer, ovarian/uterine cysts, endometriosis hysterectomy etc)*

Surgical History: *(eg,'appendix, thyroidectomy, cosmetic, C-section, Gallbladder, etc)*

Dental History: *(eg, implants upper left, root canals lower left and right, dentures, amalgam fillings lower left premolars, gum disease, etc)*

General History: *(eg, accidents, injuries, diseases, conditions, high risk issues, smoking/chemical exposures! etc)*

Diagnoses: *(eg, diabetes, hypertension, CAD, Hernia, etc etc etc.) (when and how diagnosed)*

Skin Lesions or Physical Abnormalities: *(eg, tattoos, piercing, scars, wounds, missing first finger on left hand, etc etc)*

Notes: _____