HIPAA AUTHORIZATION FORM

Jeffrey Horowitz, M.D.
Plastic Surgery

JEFFREY D. HOROWITZ, M.D., LLC

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **JEFFREY D. HOROWITZ, M.D. LLC** to use and/or disclose certain protected health information (PHI) about me to necessary parties involved in my healthcare including clinical, administrative and financial.

This authorization permits **JEFFREY D. HOROWITZ, M.D. LLC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following :

Continuity and coordination of my healthcare and for insurance claim purposes

I do not have to sign this authorization in order to receive treatment from **JEFFREY D. HOROWITZ, M.D., LLC** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

JEFFREY D. HOROWITZ, M.D.
2225 OLD EMMORTON ROAD
SUITE 111
Bel Air, MD 21014

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable