JEFFREY I. KATZMAN, MD AND ASSOCIATES AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. On occasion, Jeffrey I. Katzman, M.D., and Associates may need to use your protected health information for reasons other than treatment, payment or health care operations. This form summarizes the anticipated use of information about you which requires your authorization. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA). This is a *summary* of our full Notice of Privacy Practices which is available to you upon your request.

By signing this form, you are authorizing Dr. Katzman and his staff to disclose medical, demographic, and insurance information to aid in providing the best possible care for you. Here are some examples of how we may use or disclose your information:

- in emergency situations
- for appointment reminder calls and recall reminders
- to avert a serious threat to your health or safety
- for workers' compensation programs
- in response to requests arising out of lawsuits or other disputes.

You may revoke this authorization at any time by submitting a written request to do so to the Privacy Officer of Jeffrey I. Katzman, M.D., and Associates.

This information may be disclosed to other medical professionals and their staff, hospital representatives, insurance companies, medical representatives, pharmacy representatives, pharmaceutical representatives, and legal counsel representatives.

If you would like us to be able to speak to a family member or close friend on your behalf, you may list those names, your relationship to each person you list, and their phone number below.

1.)____

2.)____

3.)____

4.)____

Patient's name PRINTED____

Signature of patient or person authorized to sign for patient______________________________

Practice representative signature____

Date of Authorized signature_____________________