

JDR

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**Patient Authorization for Practice to Release
Protected Health Information to Third Parties**

By signing this authorization, I authorize Jeffrey D. Ries, D.O., to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Jeffrey D. Ries, D.O. to use or disclose my individually identifiable health information (describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.):

This authorization will expire on:_____.

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 his authorization in writing except to the extent that Jeffrey D. Ries, D.O. has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Jeffrey D. Ries' Privacy Officer at the above address.

Signed by: _____

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Legal Guardian's name

Relationship to Patient