Riverbend Health Care, P.C.

Sharon K. Geimer, M.D.

Internal Medicine and Pediatrics

44344 Dequindre, Ste 480
Sterling Heights, MI 48314

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

By signing this authorization, I authorize Riverbend Health Care, P.C., to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization permits Riverbend Health Care, P.C., to use or disclose the following individually identifiable health information to the person or entities listed below:

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This authorization will expire on ___________________________.
Expiration Date or Defined Event

When my information is used for disclosed pursuant to this authorization, it may be subject to re-disclosure 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 Riverbend Health Care, P.C., has acted in reliance upon this authorization.

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

______________________________ ______________________________
Patient's Name Date

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Print Name of Patient or Legal Guardian

With my consent, Riverbend Health Care, P.C., may e-mail me or mail to my home or other designated location any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements. I have the right to request that Riverbend Health Care, P.C., restrict how it uses or discloses my PHI to carry out TPO.

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However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this form, I am consenting Riverbend Health Care, P.C.,'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Riverbend Health Care, P.C., may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name Date

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Print Name of Patient or Legal Guardian