Charles A. Safely M.D.
1252 Harwood Road
Bedford, Texas 76021
(817) 284-1496

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by Text message, Email or mail in a sealed envelope, or, a brief, non-specific message may be left on your answering machine. Occasionally, we may also use "appointment cards" to remind you about upcoming appointments. If you don't approve of these methods and would like alternative reminder methods (i.e., email) please indicate those methods in the space provided (samples of appointment reminders are available upon request):

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Charles A. Safely M.D. (Check all that apply)

____Regular Mail ____Home Telephone ____Work Telephone ____Cell Phone

____Appointment Cards ____Email ____Text reminders

Other:_____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other pertinent to your healthcare and/or payment for you healthcare provided at Charles A. Safely M.D.

____Yes ____No ____N/A

If "NO", how else may we contact you regarding this information?

_____

Please list any other restrictions regarding messages or reminders about your healthcare:

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochures and/or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

____I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

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Persons Authorized to Receive Information:

Health information Charles A. Safely M.D. collects or receives about you may be disclosed to the following persons:

_____
Name of Person / Relation / Organization

_____
Name of Person / Relation / Organization

Use and Disclosure of Information:

____I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Dr. Charles A. Safely M.D.

____I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please Specify):
_____

Expiration Date of Authorization
This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation of Charles A. Safely M.D. You should contact the **PRIVACY OFFICIAL** or other authorized representative to terminate this authorization.

Three Year form

_____
Name of Patient (Print or Type)

_____	_____	_____	_____
Signature of Patient	Signature of Pt Representative	Relationship to patient	Date
_____	_____	_____	_____
Signature of Patient	Signature of Pt Representative	Relationship to patient	Date
_____	_____	_____	_____
Signature of Patient	Signature of Pt Representative	Relationship to patient	Date