

**Charles A. Safely M.D.**

1252 Harwood Road  
Bedford, Texas 76021  
(817) 284-1496

**Authorization of Use and Disclosure of Protected Health Information  
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**Appointment Reminders:** The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by Text message, Email or regular mail, or a brief, non-specific message may be left on voicemail of the phone number you provided. 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 or voice mail, may we leave messages regarding appointments, treatment and/or other pertinent information regarding your healthcare and/or payment for your healthcare provided at this office.**

Yes                       No                       N/A

**If “NO”, how else may we contact you regarding this information?**

\_\_\_\_\_

Please list any other restrictions regarding messages or reminders regarding 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