PIONEER
PHYSICIANS NETWORK

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Pioneer Physicians Network, Inc. to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that it may include information relating to **AIDs, HIV Infection, behavioral health services, psychiatric care, and treatment for alcohol and/or drug abuse.** I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal Privacy Regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules.

PATIENT NAME	DATE OF BIRTH	LAST 4 of SS#

Name and Relationship to Patient	**Phone #**

☐ DECLINED ALL

I give permission to the staff and physicians of Pioneer Physicians Network, Inc. to leave detailed information on voicemail / answering machine. _____YES ____ NO

Information to be disclosed:

☐ Consultation Reports	☐ Laboratory Results	☐ Radiology Images
☐ Discharge Summary	☐ Progress Notes	☐ Referral Information
☐ History and Physical Examination	☐ Radiology Reports	☐ **All**

I certify that I have read the provisions of this authorization, understand the content, and agree to the terms set forth within the authorization. I understand that this authorization is valid for one year from signature date unless there is a Power of Attorney or Durable Healthcare Power of Attorney on file in my record.

Patient Signature	Date
	_____/_____/_____