ARTHRITIS & RHEUMATOLOGY
CENTER OF SOUTH FLORIDA

Jigar Shah, M.D., F.A.C.R
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Ph: 954-281-8891
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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Arthritis & Rheumatology Center of South Florida will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Arthritis & Rheumatology Center of South Florida may use or disclose medical records, treatment notes, test results or any other part of the medical chart for the purpose of medical treatment, processing or collecting financial reimbursements.

By signing this authorization you agree Arthritis & Rheumatology Center of South Florida or its Business Associates may disclose your personal health care information to other treating physician's or insurance companies or other collection agencies if needed.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Arthritis & Rheumatology Center of South Florida HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Arthritis & Rheumatology Center of South Florida for as long as the PHI is maintained in the designated record set.

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You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a

finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity; or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA. This form also allows Arthritis & Rheumatology Center of South Florida to call my phone number on record for reminder of appointments, test results or financial information.

Print Patient's Name:_____

Patient's Signature:_____

Date:_____

If you are signing as the patient's representative:

Print Name & Relationship:_____

Signature of Other:_____