PRIVACY POLICY AND
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: ______________________ DOB: ________________

I, ________________________, authorize the use and disclosure of my name and protected health information by Live Oak Children's Therapy as described below:

1. Live Oak Children's Therapy may disclose this information to and this information may be used or disclosed by the following individuals or organizations:

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2. I authorize the disclosure of all protected health information for all past, present, and future periods, including, but not limited to, the following:

- All medical records;
- All treatment records;
- All diagnostic records;
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits;
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.
- The following information should NOT be disclosed by Live Oak Children's Therapy: ____
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3. This medical information may be used by the individuals and organizations listed in Section 1 above for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or

human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand the following:

   a. I have the right to revoke this authorization in writing at any time;
   b. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on any authorization, and my notice of revocation will not apply to actions taken by the requesting person or entity prior to the date they receive my written request to revoke authorization;
   c. The protected health information released in response to this authorization may be re-disclosed by the recipient to other parties and, if so, may no longer be protected by federal or state law;
   d. My treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.

6. Any facsimile, copy or photocopy of this authorization shall authorize Live Oak Children's Therapy to release the records and information requested herein. This authorization shall be in force and effect until _____________ at which time this authorization expires. If no expiration date is provided, this authorization will automatically expire one (1) year after the date that I sign it.

7. I understand that Live Oak Children's Therapy may leave a message on an automated answering device or with a person answering the telephone for the purpose of scheduling appointments.

8. I understand that Live Oak Children's Therapy may disclose my health care information to other professionals within its practice for the purpose of treatment, payment or health care operations.

9. I understand that Live Oak Children's Therapy may disclose my health information to my insurance provider for the purpose of payment or health care operations.

10. I understand that Live Oak Children's Therapy may disclose my health information to notify or assist in notifying a family member or another person responsible for my care about my medical condition or in the event of an emergency or in the event of my death. I understand that Live Oak Children's Therapy may disclose my health information to coroners or medical examiners.

11. I understand that Live Oak Children's Therapy may disclose my information to public health authorities for the following purposes: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, and reporting disease or infection exposure.

12. I understand that Live Oak Children's Therapy may disclose my health information in the course of any administrative or judicial proceeding. I understand that Live Oak Children's Therapy may disclose my health information to law enforcement officials for the following purposes: identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

13. I understand that I have the following rights related to my health information: the right to have my health information received or communicated through an alternative method or sent to an alternative location upon request, the right to inspect and copy my health information at my expense, the right to receive an accounting of disclosures of my protected health information made by Live Oak Children's Therapy, and the right to obtain a paper copy of this document at any time upon request.

14. I understand that I have the right to request restrictions to certain uses and disclosures of my health information; however, I also understand that Live Oak Children's Therapy is not required to agree to the restriction that is requested.

15. I understand that I have the right to request that Live Oak Children's Therapy amend my protected health information; however, I also understand that Live Oak Children's Therapy is not required to agree to amend my protected health information. If my request to amend my health information has been denied, I understand that I will be provided with an explanation of the denial reason(s).

16. Live Oak Children's Therapy reserves the right to amend this document at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this notice. Live Oak Children's Therapy is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information. Any questions about this document or about privacy rights should be directed to the Privacy Officer at (912) 355-3392.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS PRIVACY POLICY AND AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

____ ________________
Signature of Patient or Legally Authorized Representative Date

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Printed Name of Patient or Legally Authorized Representative

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Representative's Relationship to Patient

________________________________ ________________
Witness Signature Date