KEVIN L. JACKSON, M.D.
INTERNAL MEDICINE

Patient Authorization

I hereby consent to the use and disclosure of all Medical Date and prescription history access about me or my minor children for uses allowed by law, including for the following purposes:

Treatment Payment Health Care Operations

1. I understand that you have prepared a Notice of Privacy Practices that provides a more complete description of the uses and disclosures that you are permitted or required by law to make and that I have a right to review such notice prior to my signing this consent.
2. I understand that you may change the terms of your current Notice of Privacy Practices and if you change such notice I may contact you to obtain the most recent version.
3. I understand that I have the right to request restrictions on how you use and disclose my protected health information to carry out treatment, payment and health care operations, but that you do not have to agree to my request. Nevertheless, if you agree to my requested restriction it is binding on you.
4. I understand and consent for my health related message to be left on my answering machine.
5. I understand that I may be contacted at my place of employment if necessary.
6. I understand that I have the right to revoke this consent in writing, except to the extent that you have already taken action in reliance upon this consent.
7. I understand that this authorization will remain in effect until a written amendment or revocation has been provided to our office.
8. I understand that the names listed below will be **required to know my date of birth in order to discuss my medical condition.**

You may discuss my medical information with the following:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
You may list additional persons on the reverse side of the page.

Patient Signature: _____ Date of Birth: _____
Printed Name: _____ Date: _____
Witness: _____
Notice of Privacy Practices given to patient on: Date: _____ Initials: _____