The Oasis Institute

Patient Authorization for Use and Disclosure Of Protected Health Information

By signing this authorization, I authorize THE OASIS INSTITUTE to receive, use, and/or disclose certain protected health information (PHI) about me from:

_____

{Person or Entity to Receive/Disclose the information}

Ph#_____ **Fax#**_____

This authorization permits The Oasis Institute to use and/or disclose **the following individually identifiable health information** about me to:

_____

_____

_____

The information will be used or disclosed for the following purpose: Evaluation and Treatment.

If requested by the patient, purpose may be listed as "at the request of the individual."
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will **Expire on:** _____ / _____ / **20**_____

The practice: will □ **will not** □ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization to receive treatment from The Oasis Institute. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

THE OASIS INSTITUTE
20880 West Dixie Highway, Suite 101
Aventura, Fl. 33180
***Ph# (305) 682-8471 *Fax# (305) 682-1855**

Signed by:_____/_____-_____-

Signature of Patient or Legal Guardian DOB

_____

Print Patient's Name Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

20880 West Dixie Highway, Suite 101 Aventura, Fl. 33180
Tel: 305-682-8471 Fax: 305-682-1855
www.theoasisinstitute.com