AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

CHARLES J. BREEN, MD, PSC

1. By signing below, I hereby authorize my health information as more specifically described below to be used or disclosed: *Health and Insurance Information*. (This health information is referred to as "Protected Health Information")

2. The specific person or class or persons who are authorized to use or disclose my Protected Health Information are as follows: *Charles J. Breen, M.D, PSC*

3. The persons or class of persons to whom Charles J. Breen, MD, PSC may make the use or disclosure of my Protected Health Information are as follows: *Primary Care Physician(s), Consulting Physicians, and/or Family Members*.

4. This Authorization shall expire on: *January 1, 2026*.

5. I understand that I have the right to revoke this Authorization, if the revocation is in writing, unless:
   a. Charles J. Breen, MD, PSC has taken action in reliance upon this authorization;
   b. Or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

6. I understand that I may revoke this Authorization by: *writing to the address below.*

7. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer by protected by the law.

8. Treatment cannot be withheld for refusing to sign this authorization unless the following occurs:
   a. The reason for the exam and authorization is to be included in a medical research study, or
   b. The only purpose of the exam is to create Protected Health Information for disclosure on behalf of a third party with the understanding that an authorization to release the information is obtained. An example would be an employer requested exam for prospective employees.

By signing this authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____
Signature of Patient Date

_____
Printed name

_____
Signature of Witness Date

_____
Signature Authorized Representative Date

Description of Authorized Representative's authority to sign for patient: _____

_____

For revocation in part of in entirely, please write to:

HIPAA Contact Person
Charles J. Breen, MD, PSC
7370 Turfway Rd.
St. Luke Medical Office Building
Florence, Kentucky 41042