Emily A. Sheveland, D.O.

Board Certified – Family Medicine

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (Form B)
****This form gives permission to share certain patient health information with the people listed below.**

By signing, I authorize Dr. Sheveland to use and /or disclose certain protected health information about me to the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

The authorization permits Dr. Sheveland to use and /or disclose protected health information about me (such as dates of services, lab and test results, prescription information, recommendations of treatment, etc.). **The following is excluded from this authorization**.

I have the right to refuse to sign this authorization. I do not have to sign this authorization in order to receive treatment from Dr. Sheveland. 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 HIPPA Privacy Rule.

This authorization is in effect until revoked in writing by patient. 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:
Emily Sheveland, DO 5236 W University Dr. Suite 3200 McKinney, TX 75071

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Effective Date

_____
Print Name of Legal Guardian (if applicable)