Maternal Health Matters: Nutrition for mother and child
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Tel.718.832.7182/Fax.866.368.6432/www.maternalhealthmatters.com

Patient Authorization Form for Use of Protected Health Information

Please read carefully prior to signing:

I understand that Maria Pari-Keener of Maternal Health Matters is a registered dietitian.

I give permission to the staff of Maternal Health Matters to disclose the following health protected information to:

_____
(name of doctor)

which includes, but is not limited to, date of service, type of service provided, and referrals made to educational programs.

This protected health information is being used or disclosed in order to coordinate nutrition and health care provided with my treating medical professionals and to provide any information pertinent to my case for any insurance company, adjuster or attorney that may be potentially involved in my case. I agree to keep the staff of Maternal Health Matters informed of any changes in my medical condition that would require change in nutrition or health education needed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Maternal Health Matters at the address above. I understand that a revocation is not effective to the extent that Maternal Health Matters has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Maternal Health Matters will not condition my education program referral, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization

Important Office Policies

I understand that although Maternal Health Matters may accept my insurance coverage, I will be responsible for payment in the event of claim denial by my insurance company.

I understand that if I am more than 15 minutes late, my appointment may be rescheduled, due to other patient commitments.

I understand that in the event of an emergency I must cancel my appointment **24 hours in advance**, or be responsible for payment in full.

Your signature indicates your understanding and acceptance of above policy and that you have received a copy of this agreement.

_____
Signature of Patient or Personal Representative

Date_____