

**The Center for Medical Healing**  
**Dr. Annette DaSilva, D.O.**  
P.O. Box 726  
New York, NY 10156

**Patient Authorization for Use and Disclosure of Protected Health Information.**

By signing, I authorize **The Center for Medical Healing** to use and/or disclosure certain protected Health insurance information (PHI) about me.

This authorization permits **The Center for Medical Healing** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used to disclosed for the following purpose:

(If disclosure is 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 not expire.

The Practice will receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization form in order to receive treatment from **The Center for Medical Healing**. In fact, I have the right to refuse to sign this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA 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 entered to the privacy officer at:

**The Center for Medical Healing**

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable

\_\_\_\_\_  
Date