## Branson Clinic, LLC

### Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Branson Clinic, LLC to use and/or disclose certain protected health information (PHI) about me to _____. This
Name of entity to receive this information
authorization permits Branson Clinic, LLC 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.):

_____

_____.

I understand that any part of my protected health information that is categorized as "psychotherapy notes" will **not** be included under this authorization.

The information will be used or disclosed for the following purpose:
_____.
If the above is left blank, purpose shall be "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 _____.
{Expiration Date or Defined Event}

I do not have to sign this authorization in order to receive treatment from Branson Clinic, LLC. 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:

Organization Name: Branson Clinic, LLC
Address:110C Business Park Drive, Branson, MO 65616
Telephone Number: 417-239-0125
Contact Person: Darren Allison

_____ _____
Printed Name of Patient or Legal Guardian Date

_____ _____
Signature of Patient or Legal Guardian Date

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