ROBERT J. KLEIN, DO

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Robert J. Klein, DO to use and/or disclose certain protected health information (PHI) about me to ________________________

____

This authorization permits Robert J. Klein, DO to use and/or disclose the following individually identifiable health information about me: ____all Private Health Information____

____

The information will be used or disclosed for the following purpose: _________________ ___patient request____.

This authorization will expire one year from the date of signature or __until revoked___.

I do not have to sign this authorization in order to receive treatment from Robert J. Klein, DO. 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 redisclosure 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: 1652 42nd Street, NE

Cedar Rapids, IA 52402

_________________________________	__________________________
Signature of Patient or Legal Guardian	Relationship to Patient
_________________________________	____________________
Patient's Name	Date
_________________________________	
Print Name of Patient or Legal Guardian	