

**EMP**  
Emergency Medicine Physicians

**HMP**  
Hospitalist Medicine Physicians

**EPMG**  
Emergency Physicians'  
Medical Group, Inc.

MBFS Use Only

IDXRNR \_\_\_\_\_  
Facility \_\_\_\_\_  
Date Received: \_\_\_\_\_

**MBFS**  
Dressler Rd. NW, Canton, OH 44718  
1-800-982-8177 Fax (330) 492-8489

**MBFS**  
300 Douglas Blvd., Ste 200 Roseville, CA 95661  
1-888-530-9480 Fax (916) 543-1135

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. I authorize my health care provider and his/her medical billing company, Medical Billing and Financial Services, Ltd. (MBFS), to use and/or disclose the medical and billing information about me described below.
2. My health care provider and MBFS are authorized to disclose my health information to the following individual(s) and/or organizations such as carriers, insurance companies, law firms, etc.: (Must fill out)  
\_\_\_\_\_  
\_\_\_\_\_
3. I would like my health information disclosed for the following reason(s): \_\_\_\_\_  
\_\_\_\_\_
4. The information that may be used and/or disclosed is: (Must check one)  
 Any and all medical and billing records concerning all medical care that I have ever received from my health care provider  
 Any and all medical and billing records concerning medical care I received from my health care provider on: \_\_\_\_\_  
 Other: \_\_\_\_\_
5. The following items must also be checked to be included in the use and/or disclosure of health information pursuant to this Authorization:  
 (a) HIV/AIDS related information and/or records       (c) Genetic testing information and/or records  
 (b) Mental health information and/or records       (d) Drug/alcohol diagnosis, treatment and referral information
6. I understand that if a person or entity that receives information pursuant to this Authorization is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release my health care provider, his/her employer and MBFS from all liability arising from this disclosure of my health information.
7. I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Privacy Officer at 4535 Dressler Road, N.W., Canton, OH 44718. I understand that a revocation is not effective to the extent that my health care provider and MBFS have already taken action in reliance upon this Authorization.
8. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
9. This Authorization will expire six (6) years from the date signed below, or \_\_\_\_\_, whichever is earlier.

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Name of Patient's Personal Representative/Guardian, If Applicable (Please Print)

\_\_\_\_\_  
Address of Patient

\_\_\_\_\_  
Address of Personal Representative/Guardian

\_\_\_\_\_  
Social Security No.:

\_\_\_\_\_  
Description of Representative's Authority to act for the Patient

\_\_\_\_\_  
Account No.:

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Personal Representative/Guardian

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Date: