Robert A. Crook, D.O.

Standard Authorization of Use and Disclosure of Protected Health Information

- The information covered in this authorization form includes medical mail outs, lab test results, diagnostic testing results, pertinent medical information and account status.
- You have the right to request restriction of use and disclosure of your health information for any purpose than those listed. Any changes to this information must be submitted in writing to this office.
- Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once we disclose this information to another party, it becomes their responsibility to protect your right of privacy.

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by initialing the appropriate response.

_____Please call me at this number: _____or_____

If I am not available at one of the numbers above, I authorize you to leave a message on my answering machine and/or voice mail.

◯Yes ◯No

I authorize you to leave a message with my spouse or family member

◯Yes ◯No

_____Please mail my results:_____

If No, how may we contact you regarding this information?_____

Please list any restrictions regarding your medical information._____

Please specify any person(s) or organization(s) with whom information may be

disclosed:_____

I understand that it is my responsibility to notify **Healthplus** in writing if this information changes.

Patient Signature:_____

Witness:_____Date:_____