P. O. Box 947, Valdosta, GA 31603-0947
Phone 1-877-949-0940 Fax (229) 249-9840

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **TLC BENEFIT SOLUTIONS** to disclose certain protected health information (PHI) about me to _____
Authorized Representative's Name

This authorization permits **TLC BENEFIT SOLUTIONS** 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.): _____

_____

OR check this box

☐ All information relating to my health care

The information will be used or disclosed for the following purpose: PERSONAL USE

This authorization will expire **one year from the Date below.**

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 refuse to sign this authorization.

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 TLC Benefit Solutions Inc.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

_____
Print Patient's Name Date

_____

For Bookkeeper Use Only:
Mail/fax a copy of this form to TLC Benefit Solutions, Inc., P.O. Box 947, Valdosta, GA 31603, 229-249-9840 (FAX)