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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
(Last) (First) (Middle Initial)

Date of birth: _____ Date authorization initiated: _____

Information to be released (check only one):

- ☐ All records pertaining to my care
- ☐ Pertaining to treatment of (identify condition): _____
- ☐ Pertaining to treatment received from: _____ to: _____
- ☐ Other (describe in detail): _____

_____

The reason I am authorizing this release is:

- ☐ My request
- ☐ Other (describe): _____

Person(s) Authorized to Make the Disclosure: _____

Person(s) Authorized to Receive the Disclosure: _____

This Authorization will expire after 1 year, or on: _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the protected health information has already been used or disclosed or if my authorization was obtained as a condition of my obtaining insurance coverage and the insurer has a legal right to contest a claim.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health care information to the above-named person or organization.

Patient/Personal Representative Signature: _____ Date: _____

Relationship to Client if Personal Representative: _____