Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above named practice.
(Circle include or exclude for each of the following)

Include	or	Exclude:	My health information related to drug abuse.
Include	or	Exclude:	My health information related to alcohol abuse.
Include	or	Exclude:	My health information related to HIV/AIDS.
Include	or	Exclude:	My health information related to psychological or psychiatric conditions, including psychotherapy notes.

☐ My health information relating to the following treatment or condition:_____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

Address: _____ Phone #: _____

Reason(s) for this authorization (check all that apply):

☐ at my request ☐ Other (specify): _____

This authorization ends: ☐ on (date): _____

☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

-To take part in a research study.

-To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not effect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

-Fill out a revocation form.

-Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, etc.)**