

Name of Practice: _____

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

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: _____ City _____ State _____ Zip _____

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

- at my request
- other (specify) _____
- check here only when [insert physician or clinic name] requests the authorization for marketing purposes
- check here only when [insert physician or clinic name] will get something of value for providing health information for marketing purposes

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. or
- 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 affect 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. The form is available from the office, or
- 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, personal representative, etc.) _____