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) ______________________

____

____

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.)