

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Name of Practice to *release* health information:

Name (or title) and organization: _____			
Address: _____	City: _____	State: _____	Zip: _____
Fax: _____	Email: _____		

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

- All my health information maintained by the above-named practice
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): _____
- Other: _____

Exclude the following health information: Drug/Alcohol Abuse HIV/AIDS Psychological/Psychiatric Conditions

Name of Practice or recipient to *receive* health information:

Name (or title) and organization: _____			
Address: _____	City: _____	State: _____	Zip: _____
Fax: _____	Email: _____		

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

- At my request
 - Other
- (Specify): _____

This authorization ends (If no selection is made it will automatically end in 180 days):

- 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. To revoke this authorization, 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

Relationship (Parent, Legal guardian, personal representative, etc.)

Office Use Only:	Date Received: _____
	Staff Initials: _____