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):

□ I am an OB patient who is transferring care.

□ 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: ____________________

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