

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name		Maiden Name
Social Security Number	Date of Birth	Phone Number
Address		

1. I authorize _____ (referred to as "Health Care Provider") to use and/or disclose my/the patient's protected health information as described below.

2. I authorize the following person(s) or organization(s) to receive the information:

NAME

STREET ADDRESS, CITY, STATE AND ZIP CODE

3. I authorize the following information to be disclosed pursuant to this Authorization—

ALL MEDICAL RECORDS AND BILLING RECORDS FOR ALL DATES OF TREATMENT

Further, I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism and/or Acquired Immune Deficiency Syndrome (AIDS) and/or testing for antibodies to the AIDS virus (HIV) and/or psychiatric/psychological conditions and/or psychiatric/mental health treatment.

4. The purposes for the use or disclosure are at the patient's request and for treatment purposes.

5. The Health Care Provider may not condition treatment on whether or not you sign this Authorization. If you refuse to sign this Authorization the Health Care Provider will not withhold treatment from you and will not release the information to the person or organization specified above.

6. I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

7. I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing by sending a letter to the attention of the Manager of the Medical Records Department at the Health Care Provider's mailing address. I understand that if I revoke this Authorization, it will not affect any actions that the Health Care Provider took before it received my revocation letter.

8. This Authorization will expire one year after the date below.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

DATE

Printed name of patient's representative, if applicable: _____

Relationship to patient:

Parent *Legal Guardian *Other: _____