



AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Primary Physician: _____ Date of Request: _____

I hereby authorize _____ [Name of Practice] to:

___ **Disclose** the following protected health information:

___ **Receive** the following protected health information:

Yes___ No___ Operative notes and reports

Yes___ No___ Physician’s progress notes

Yes___ No___ X-Rays

Yes___ No___ Entire medical record (Including HIV, AIDS, Alcohol or drug abuse and mental health records)

Yes___ No___ Lab/test results

___ Other (please specify) _____

Purpose of Release. The protected health information will be used or disclosed for the following purpose(s):

___ Ongoing treatment and care

___ Specialist referral

___ Other (please specify) _____

Releasing Party. The person(s) / class of persons authorized to make this use or disclosure is/are:

Name: _____ Address: _____

Phone: _____ Fax: _____

Receiving Party. The person(s) / class of persons to whom the Medical Practice may make the use or disclosure is/are:

Name: _____ Address: _____

Phone: _____ Fax: _____

Expiration. This authorization will expire on _____ (specific date) or when _____

_____ (an event that relates to the patient or the purpose of the use of disclosure).

Revocation. The patient may revoke this authorization in writing at any time, except to the extent that the Medical Practice has acted in reliance on this authorization. Revocation may be made in writing on a form provided by the Medical Practice and delivered to the Privacy Officer.

Redisclosure. Information used or disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

Patient’s Rights. The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, the Medical Practice will not condition treatment, payment or other health care benefits on the giving of this authorization. The patient shall receive a copy of this authorization.

Patient or Personal Representative Date

(Personal Representative is a person authorized by law to make health care decisions on behalf of the individual, i.e., parent/legal guardian or Durable Power of Attorney for Healthcare)

_____ Description of Personal Representative’s Authority