

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

**Printed Patient's Name** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**Patient's Date of Birth** \_\_\_\_\_ **Patient's Social Security Number** \_\_\_\_\_

**Person/Organization Authorized to Release Information:**

**Person/Organization Authorized to Receive Information:**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, State & Zip Code \_\_\_\_\_

City, State & Zip Code \_\_\_\_\_

**For the following protected health Information:**

- 2 year Summary
- Radiology reports
- Physician Progress Notes
- Entire record
- Lab/test results
- Other (include dates of Service) \_\_\_\_\_

**Purpose of Release:**

- Continuity of Medical Care
- Transfer of Medical Care
- Self/Personal Reasons
- Legal Reasons
- Insurance
- Other (please specify) \_\_\_\_\_

**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.

**Revocation.** I understand that I 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.

**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. This authorization will expire automatically one year from the date on which it is signed.

\_\_\_\_\_  
**Patient's or Personal Representative's Signature**

\_\_\_\_\_  
**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**