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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____ Telephone: (___) - - _____
Address: _____ City/State/Zip: _____

I hereby authorize the protected health information regarding the above-named person be exchanged between:

Person/Institution: _____ Person/Institution: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Telephone: (___) - - _____ Telephone: (___) - - _____

Information to be used or disclosed is as follows:

☐ Entire Record ☐ Immunizations ☐ Lab Results ☐ Allergy List
☐ Medication List ☐ Diagnosis List ☐ Diagnostic Test ☐ Operative Report
☐ Consultation Report ☐ ER Report ☐ Discharge Summary ☐ Recent History
☐ Other *(please specify)*:

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

This information will be used or disclosed for the following purpose:

☐ Requested by the patient for personal records
☐ Sharing with other health care providers for continuing care
☐ Other *(please specify)*: _____

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless I specify differently, this authorization will expire on: _____

If not otherwise specified this release will expire within 90 days of the date of signature.

I understand that once the above information is disclosed, it may be disclosed again by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____

You must be able to furnish proof of relationship or authority to act for the patient upon request