AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections must be completed, and form signed and dated.

I. Patient Information:

PATIENT NAME	DOB / /	TELEPHONE ( ) -
ADDRESS	CITY/STATE/ZIP	

II. The information is to be disclosed by: The information is to be provided to:

NAME OF FACILITY		NAME OF PERSON/ORGANIZATION/FACILITY	
ADDRESS		ADDRESS	
CITY/STATE		CITY/STATE/ZIP CODE	
TELEPHONE ( ) -	FAX ( ) -	TELEPHONE ( ) -	FAX ( ) -

III. The purpose or need for this disclosure is:

☐ Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify):* _____

IV. The information to be disclosed from my health record:

►***Please circle applicable service lines:***

MEDICAL (*Primary Care*) **REHABILITATION SVCS** **BEHAVIORAL HEALTH** **DENTAL SVCS**

►***Please check the applicable clinical documentation being requested:***

☐ Encounters and Procedures ☐ Lab Results ☐ Vaccination Records
☐ Medication List ☐ Imaging Results ☐ Other *(specify)*_____
☐ Only information related to *(specify)* _____
☐ Only the period of events from_____to_____.

►***If you would like any of the following sensitive information disclosed, check the applicable box(es) below:***

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ HIV/AIDS-related Treatment ☐ Psychotherapy Notes ONLY (By checking this box, I am waiving any psychotherapist-patient privilege.)

V. Authorization:

By signing below, you hereby authorize the use or disclosure of information that is protected under federal law for the time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information. This information is protected under Federal Law and you have the right to revoke this authorization is writing. Please be advised, however, that any revocation will be effective only to the extent we have not already acted reliant on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

I hereby voluntarily authorize the disclosure of information from my health record:

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE *(State relationship if legal representative)* ***X***	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This authorization is valid for one year from the date of signature, or until the following date or event: _____