Authorization to Use or Disclose My Health Information

Patient name: ______________________________ Date of birth: ______________

Previous name: ______________________________

I. MY AUTHORIZATION: You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the practice.

I understand that this may include information related to substance abuse, sexually transmitted infections or psychiatric conditions. Please specify any information that should be EXCLUDED: ______________

☐ My health information relating to the following treatment or condition: ______________

☐ My health information for the date(s): ______________

☐ Other: ______________

****COPYING FEE MAY APPLY****

I authorize release of my health information from:

____
Provider or Facility Name

____
Address

____
City **State** **Zip Code**

You may disclose this health information to:

____
Provider or Facility Name

____
Address

____
City **State** **Zip Code**

Reason(s) for this authorization:

☐ at my request

☐ other (specify): ______________

This authorization ends:

☐ one year from today

☐ on (date): ______________

II. MY RIGHTS: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, fill out a revocation form at the office which owns the records in question, or write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____
Patient or legally authorized individual signature

____
Date

____
Printed name if signed on behalf of the patient

____
Relationship (e.g. parent, legal guardian, personal representative)