AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:____

Last First Middle

Home Address: ____

____

Home Telephone:______________________ **Date of Birth**: ____________

Social Security Number:______________

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report

☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report

☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record

☐ Other____

Records for the period (dates) from ______________ to ______________

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

Name of Person or Class of Persons who may disclose my health information

____

To release records to: ____

____

____

Please list telephone number and fax number: ____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the ________ day of _________, 200____.

☐ Until __________________________________ fulfills this request.

☐ Until the following event occurs: ____

☐ Other:

PURPOSE: I authorize the_______________________ to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):____

I understand that once my health information has been disclosed to the recipient, the medical facility releasing my health information cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that the health facility may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the health facility; except, however, if my treatment at the health facility is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the health facility may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the health facility's Privacy Office at the practice address. The revocation will be effective immediately upon the health facility's receipt of my written notice, except that the revocation will not have any effect on any action taken by the practice in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize ____ to use or disclose my health information in the manner described above.

______________________________________ **____________________**

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

__________________________ ____________________ ____________________

Signature of Authorized Personal Representative

Relationship to Patient

Date