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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 above named practice

(Circle include or exclude for each of the following)

Include or Exclude: My health information related to drug abuse
Include or Exclude: My health information related to alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

❑ My health information for the date (s): _____
❑ Other: _____

You may disclose this health information to:

Name (or title) and organization: _____
Address: _____
City _____ State _____ Zip_____ Telephone Number:

Reason(s) for this authorization (check all that apply):

❑ at my request
❑ other (specify) _____

_____

This authorization ends: ❑ on (date) _____
❑ when the following event occurs _____

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 above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is to 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 Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

STANDARD CHARGES FOR MEDICAL RECORDS WILL APPLY.