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Patient Authorization to Use or Disclose protected Health Information

To: _____ Patient Name: _____
_____ Date of Birth: _____
_____ SSN: _____
_____ Alias' _____

I authorize the entity above to disclose my protected health information as described on this form to the recipients listed below. I have read this authorization and understand what information will be disclosed, who may disclose the information, and the recipients of that information. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be disclosed (check all that apply):

- My entire medical record (Note: this requires an explanation why the entire record may be disclosed)
- Medical Data/ Information as related to: _____

Other: _____

Purpose of the information: _____

Reason for transfer, if applicable: _____

New or Forwarding address, if applicable: _____

Name, address and fax number of entity to receive protected health information, according to the terms of this authorization:

Instructions for Release: _____

This authorization shall expire on _____, after this date, it can no longer be used to disclose my protected health information without first obtaining a new authorization.

I understand I have the right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. I understand in order for a revocation to be effective, it must:

- Be Written
- Be sent and received by the Privacy Officer of the covered entity to whom I made this authorization
- Include my name, address, and patient number, if applicable
- Include the effective date of this authorization, and the recipient according to this authorization
- State a desire to revoke this authorization
- Be dated and signed by me

I fully understand and accept the terms of this authorization.

Patient Signature

Date

Witness Signature