AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

1

Patient Name:	**Telephone:**
Address:	**Date of Birth:**
	Social Security No.:
Account Number(s):	
Facility:	(hereinafter referred to as the "Facility")

2 **Specify Information to be Disclosed:**

- ☐ Billing records for date of service(s): _____
- ☐ Medical records for date of service(s): _____
- ☐ Other: _____

3 By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my *initials*, if any such information will be used or disclosed pursuant to this Authorization.

- ☐ Mental Illness _____
- ☐ Development Disability _____
- ☐ Psychotherapy Notes _____
- ☐ HIV / AIDS Testing, Diagnosis or Treatment _____
- ☐ Communicable Disease _____
- ☐ Substance Abuse, Prevention or Treatment _____
- ☐ Sexual Assault _____
- ☐ Child Abuse or Neglect _____
- ☐ Genetic Testing _____
- ☐ Domestic Abuse _____
- ☐ Elder Abuse _____
- ☐ Other _____ _____

4 **RECIPIENT:** Name and address of persons or class of persons to whom _____ may disclose my health information:

_____ Phone: _____

_____ Fax: _____

_____

_____

5 **EXPIRATION:** this authorization shall expire upon this expiration (date or event):

_____

6 **PURPOSE:** I authorize the Facility 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): Note: "at the request of Patient" is sufficient if the Patient is initiating this Authorization: _____

_____

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7 I understand that once the facility discloses my health information to the recipient, the facility cannot guarantee that the recipient will no redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable law governing the use and disclosure of my health information.
I understand that the facility may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

8 I understand that I may at any time make a written request to the Facility to inspect and/or obtain a copy of my health information, and that the facility will within thirty (30) days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for denial, my review rights (if any), and instructions as to how and to whom I may register a complaint regarding the denial.

9 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 Facility; except, however, if my treatment at the Facility is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Facility may refuse to treat me if I do not sign this Authorization.

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

11 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 below, I hereby, knowingly and voluntarily, authorize the Facility to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If patient is a minor or is otherwise unable to sign his Authorization, obtain the following signatures:

_____ _____ _____
Signature of Personal Representative | Description of Authority | Date