Authorization to Use or Disclose Protected Health Information

I hereby authorize ____to use or disclose the following information from the health records of the individual whose name is described below.

Patient Name:____ Date of Birth:__________________
(Please Print)

Address:____
(City) (State) (Zip)

Phone Number:____________________________ Social Security #:_____________________________

I authorize **the above named facility(s)** to release medical, mental, alcohol and/or drug abuse, HIV (human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name:____

Address:____
(City) (State) (Zip)

- This information for which I'm authorizing disclosure will be used for the following purpose:

Description:____

Dates of service to be released:____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated).

- ☐ Abstract
- ☐ Discharge Summary
- ☐ Psychotherapy Notes
- ☐ Treatment / Service Plan
- ☐ Psychiatric Evaluation
- ☐ Progress Notes / Clinical Assessment
- ☐ Lab results
- ☐ Medication Records
- ☐ Other: (please describe) ______________________
____

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the release information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed:____ Date:___________ Time:__________
Patient or Authorized Person, Parent ☐ Legal Guardian ☐ Executor ☐ Power of Attorney ☐

☐ Photo ID checked

Witness:____ Date:___________ Time:__________

Copied by:__________________________ Date:___________ Time:________ Pages copied:__________

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