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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

I hereby authorize:_____

To release to:_____

Information to be released:

_____All Records
_____Office Visit Notes
_____Special Procedure Notes
_____Lab/Pathology Results
_____X-Ray/Radiology Reports
_____Hospital Records
_____Other_____
_____

Note: If these records contain any information from previous providers related to HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing disclosure of this information.

The above information is released for the following purpose and that purpose only. Any other use is forbidden.

Purpose of Release: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility benefits unless allowed by law. By signing below, I represent that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

This authorization will expire no later than: ____/_____/_____and may not be valid greater than one year from the date of signature.

_____ _____
Patient Signature or Personal Representative **Date**

_____ _____
Printed Name of Patient Representative **Representative's authority to sign for patient (i.e. Parent, Guardian, Power of attorney)**