AUTHORIZATION FOR DISCLOSURE

OF PROTECTED HEALTH INFORMATION

Patient Name: ____Date of Birth: ____________

Address: ____Phone Number: ___________

I hereby authorize the use or disclosure of protected health information as described below:

Specific information to be used or disclosed:

_____ Medical records as described ____

_____ X-ray films as described ____

_____ Billing records as described____

_____ Other ____

I understand that my records are confidential and cannot be disclosed without my written permission, except when otherwise permitted by law. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence/abuse. I understand that information disclosed according to this authorization may be subject to redisclose by the recipient and may no longer be protected.

Entity (ies) to whom disclosure may be made: ____

Address ____

____

Phone ____

I understand that I have the 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 health information management department. 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. Unless otherwise revoked, this authorization will expire on the following date:_____________. If I fail to specify a date, this authorization will expire in one year.

____ ____________________

Signature of Patient/Legal Representative Date Signed

____

Printed Name of Legal Representative & Relationship to Patient

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