PATIENT REQUEST/AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name: _____ Birthdate: _ _ /_ _/_ _ _ _
SSN#: x x x - x x - _ _ _ _

Information released from: Information released to:

Name	Name
Address	Address
City	City
State Zip	State Zip

Term of This Authorization: ___ This request only ___ One year from date of signature

Type of information to be released:

___ Clinic office notes
___ History & Physical
___ Consultations
___ Immunizations
___ Laboratory reports
___ Radiology reports
___ All records
___ Other _____
___ Specific dates _____

Highly Confidential Information - Specific authorization must be given to use and/or disclose the following information:

___ Mental Health Treatment
___ Substance Abuse Evaluation or Treatment
____ Sexually Transmitted Disease Information
____ HIV/AIDS Testing or Treatment

Reason for Disclosure:

___ Continuing Care ___ Insurance ___ Attorney ___ Personal ___ Other

I have read and understand the terms of this authorization and 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 disclosing entity to use or disclose my health information in the manner described above.

I understand that once disclosed to the recipient, the disclosing entity cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Fees for Copies: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. In some cases, you may be required to pre-pay for the copies; if not, then your copies may be mailed along with an invoice.

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

_____ _ _/_ _/_ _ _ _ (_ _ _)_ _ _ - _ _ _ _
Signature of Patient/Guardian/ Personal Representative Date Phone

_____ _____
Description of Authority to Act for Patient Signature of Witness

Information was: ☐ *Given to Patient/Representative* ☐ *Mailed* ☐ *Faxed* ☐ *Other:* _____

Information was released in the form of: ☐ *Print* ☐ *Electronic*