

AUTHORIZATION FOR USE OR DISCLOSURE OF MY HEALTH CARE INFORMATION

Patient name _____ Date of Birth _____

Previous name _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____

- Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Psychiatric disorders/mental health
- Sexually transmitted diseases
- Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address (optional): _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- at my request
- check only if [practice/ facility] requests the authorization for marketing purposes
- other (specify) _____
- check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends:

- on (date): _____
- when the following event occurs: _____
- in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)