

**AUTHORIZATION FOR USE
AND / OR DISCLOSURE OF PATIENT
HEALTH INFORMATION**

IMPRINT AREA

I understand that _____ will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize _____

NAME OF DISCLOSING PARTY

ADDRESS

CITY

STATE

ZIP

To disclose to

NAME OF RECIPIENT

ADDRESS

CITY

STATE

ZIP

Records and information pertaining to

NAME OF MEMBER/PATIENT (LIST OTHER NAMES USED)

SOCIAL SECURITY NUMBER

DATE OF BIRTH

ADDRESS

TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from date of signature unless a different date is specified here _____.

REVOCACTION: This Authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS:

Check the box and initial to specify which type of information is to be disclosed.

MEDICAL INFORMATION _____
INITIAL

PSYCHIATRIC INFORMATION

SIGNATURE DATE

DRUG/ALCOHOL INFORMATION

SIGNATURE DATE

RESULTS OF AN HIV BLOOD TEST

SIGNATURE DATE

OTHER HEALTH INFORMATION _____ (specify below)
INITIAL

Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the following purposes: _____

Date: _____ Signature: _____

If signed by other than patient, indicate relationship: _____
