MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____

DATE OF BIRTH:_____ Medical record #_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI	Name and Address of Individual/Facility to Disclose PHI
_____	_____
_____	_____
_____	_____

Information authorized for use or disclosure, or to be obtained:

☐ History & Physical ☐ Discharge Summary ☐ Operative Report ☐ ER Record ☐ Consultation ☐ Lab Reports

☐ Progress Notes ☐ X-ray Reports ☐ Other _____

☐ Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient of patient's representative

☐ Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

Processed by (Print Name & Dept): _____

Original: Releasing entity Copy: Originator Copy: Patient or representative (Required)