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## AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Provider: _____

Address of Provider: _____

_____

Tel #: _____

Fax#: _____

**Recipient and Address for Delivery of Records:**

**Purpose:** I understand that the specific purpose of this authorization is:

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**Information to be disclosed:** This authorization permits the above named health care provider to disclose the following medical records.

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes, billing information, correspondence, and records from my other healthcare providers that the above-named health care provider may hold.

☐ All of my healthcare information described above except for the following:

_____.

☐ Only the following records or the types of health information: (Insert dates of treatment, types of treatment or other designation.)

_____.

_____.

**Term:** This Authorization will remain in effect for 3 months from the date of this signed authorization.

**Redisclosure:** I understand the that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose 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.

**Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider.

**Revocation:** I understand that the Authorization will remain in effect until the term of this Authorization expires, or I provide written notice of revocation to my healthcare provider at my health care providers regular office address. The revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

**Questions:** I may contact my healthcare provider for any answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this Authorization from my healthcare provider.

**Photocopy:** A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____ _____
Signature Date Signature of Witness

Name: _____
(Please Print)

If individual is unable to sign this Authorization, please complete the information below.

_____ _____ _____
Signature of Personal Representative Legal Relationship Signature of Witness

_____ Name: _____
Date (Please Print)

**A $30.00 records copy fee will apply. Records will be sent within 10 days of receipt of payment and signed Request for Release of Medical Records form. An additional $10.00 fee applies for a RUSH request.**

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| ( ) AMEX ( ) Discover ( ) Visa ( ) MasterCard | |
| Card # | Amt: |
| Signature: | Exp Date: |