

**AUTHORIZATION TO USE OR DISCLOSE  
PROTECTED HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that once information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

**Records Released From:**

**Records Released To:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Fax #

\_\_\_\_\_  
Fax#

**This information will be used for:**

- my personal records
- sharing with other health care providers (as needed)
- other (please describe) \_\_\_\_\_

**Check type of Information Authorized to be Used and/or Disclosed**

- Patient Demographic Information
- office Notes
- consultation reports
- lab/x-ray reports
- diagnostic tests
- ER Reports
- history/discharge Summary
- other (please describe) \_\_\_\_\_
- Entire record (will not include records not prepared by or on behalf of Provider unless those items are also selected)
- Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.

**FOR TREATMENT DATE (S)** \_\_\_\_\_

The information disclosed may include matters regarding mental health, alcohol or drug abuse and infectious diseases, including AIDS HIV test results. I understand that such information may be subject to special protections. If you do not wish such information to be released, state information to be excluded \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before the revocation was received. Unless otherwise revoked, this authorization expires 6 months from the date signed below.

I have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

A faxed or photocopy of this authorization shall be considered valid. I give permission for this information to be faxed if necessary.

\_\_\_\_\_  
Patient or legal Representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient: \_\_\_\_\_