Print

Authorization to Use or Disclose Protected Health Information Form

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Verification of Identity: _____ Phone Number: _____
(Driver's License, Passport, ID Card, etc.)

If you are not the patient and are authorizing the disclosure of protected health information, complete the below.

Name: _____ Relationship to Patient: _____

Legal Authority: _____ Verification of Authority: _____

Verification of Identity: _____ Witness: _____
(Driver's License, Passport, ID Card, etc.)

By signing this form, I _____ authorize _____ to release the following protected health information: _____

> Please release my protected health information to:

Physician Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I further authorize the disclosure of information related to:
(Check all that apply.)

- ☐ Mental Health Conditions or Treatments
- ☐ Substance Abuse
- ☐ Genetic Disorders
- ☐ HIV/AIDS
- ☐ Other Sexually Transmissible Diseases

The purpose of the use or disclosure is: _____

I further authorize the disclosure of:
(Check all that apply.)

- ☐ Records created by other health care providers, not associated with the organization or entity above, which may be included in the health information described.
- ☐ Records of the same type listed above for disclosure, created after today's date, until the expiration date shown below, or six (6) months from the date of this authorization, whichever comes first.

I understand that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations. I hereby release (the facility) and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire in **six (6)** months from the date signed below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in **CFR 164.524**. If I have questions about disclosure of my health information I can contact a Medical Records Supervisor, Member Services or the Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date