AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHI FORM

PATIENT NAME:____

DATE OF BIRTH:____

(1) I hereby authorize ____ [*doctor/practice/facility name, insurance company, etc.*] to use or disclose my Protected Health Information (PHI) for the purposes as described in this authorization.

(2) Specifically describe the Protected Health Information that you are authorizing to be used or disclosed:

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(3) Describe the purpose of the requested use or disclosure. In the event you are initiating the authorization, please state "at the request of the patient."

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(4) I authorize the use or disclosure of my protected health information to [*insurance company, attorney, individual(s), doctor/facility name, etc.*]:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

(5) This authorization shall expire on the following date or event that relates to me or the purpose of the use or disclosure (e.g. end of treatment):

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(6) Your treatment will not be conditioned on your providing an authorization for the requested use or disclosure.

(7) By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this authorization. I acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

(8) I understand I have a right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it. My revocation is effective upon the date that the signed revocation is received or the date specified on the signed revocation, whichever is later. All uses and disclosures of my Protected Health Information covered in this authorization will then terminate. The revocation must be signed and dated by the patient or the patient's authorized personal representative.

____ ____________________

Patient or Representative Signature Date

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Description of Authorized Representative's Authority to Sign for Patient (if applicable)