Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

Previous name(s):_____

I. Authorization:

You may use or disclose the following Health Information (Check all that apply):

- ☐ All Health Information in my medical record;
- ☐ Health Information in my medical record relating to the following treatment or condition:

  _____
- ☐ Health Information in my medical record for the date(s): _____
- ☐ Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (Check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted Diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this Health Information to:

Name (or title) and organization: _____

Address: _____City:_____State:_____Zip:_____

Reasons for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify): _____

Authorization Expiration: *(This authorization does not permit disclosure of Health Information more 90 days after it was signed.)*

- ☐ In 90 days from the date signed
- ☐ on (date): _____
- ☐ When the following event occurs: _____

(no longer than 90 days from date signed)

II. My Rights:

I understand I do not to sign this authorization in order to receive healthcare. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
- Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____a_

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)