Read entire document before signing

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Robin L. Bailey, M.D. 18257 Industrial Drive, Suite B Meadville, PA 16335 814-807-1700 Fax: 814-217-6742

Patient Name: _____ **Date of Birth:** ____/____/____

1. I authorize the use or disclosure of the above named individual's health information described below.

2. **Robin L. Bailey, M.D.**is authorized to: _____ make this **disclosure to** the below named person(s)/organization(s)

   _____ **receive disclosed** information **from** below named person(s)/ organization(s)

3. The following person(s) or organizations(s) are authorized as indicated above:
   Name/ Address:_____
   Name/ Address:_____
   Name/ Address:_____

4. The type of information that may be disclosed is as follows:
   - ☐ Diagnostic and medication history
   - ☐ Entire record
   - ☐ Summary only
   - ☐ Laboratory tests within past 12 months
   - ☐ Other (please give specific description) _____
     _____

5. I understand that the information to be disclosed includes mental health information, may include information relating to AIDS or HIV, and may include information about treatment for drug, alcohol, or substance abuse.
   I understand that once the information listed above has been disclosed, it could potentially be re-disclosed because the information may no longer be protected by federal privacy laws or regulations.
   Please specify any restrictions of the above information: _____
   _____

6. This information I am requesting to be disclosed will be used for:
   - ☐ My medical treatment
   - ☐ Insurance payment/reimbursement
   - ☐ My personal use
   - ☐ To evaluate my eligibility for life insurance coverage or eligibility for *Disability benefits*
   - ☐ At the request of my attorney (name _____) for _____
   - ☐ Other (please describe)_____

7. I understand that I have the following rights:
   - **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Robin L. Bailey, M.D. except when health services are solely for the purpose of reporting to a third party.
   - **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any release already made in response to this authorization. To revoke this authorization, you must submit a written revocation to:
     Robin L. Bailey, M.D., 18278 Technology Dr., Meadville, PA 16335

8. Expiration of this authorization: ☐ one month after the termination of treatment in the practice of Robin L. Bailey, M.D.
   ☐ Other: _____

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization.

Signature: _____ Date:_____
(Signature of patient, parent, legal guardian, or other legally authorized representative)

Name of representative (please print) _____ Relationship to patient_____