Murphy Creek Wellness

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Authorization to Use and Disclose Health Information

Facility Name: _____

To disclose to: _____

Previous Providers Name _____

Name of Recipient _____

Facility Address _____

Address _____

City, State Zip _____

City, State Zip _____

Records and information pertaining to:

Patient name (list other names used) _____ SS# _____ Date of Birth _____

Address _____ Phone number _____

For the purpose of:_____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here_____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Initial to specify which type of information is to be disclosed, and then sign and date.

Medical information	_____ (initials)	Psychiatric information	_____ (initials)
Drug/Alcohol Information	_____ (initials)	Results of HIV Test	_____ (initials)
Genetic Records	_____ (initials)	STI Screening	_____ (initials)

Signature:_____Date:_____

Print Name:_____Relationship to patient:_____

A copy of this authorization is as valid as the original.