# AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMAITON

Patient Name: _____ Date of Birth: _____

Address: _____

Covering the period(s) of health care: From: _____ To: _____

Information to be disclosed: ☐ Complete health record OR

Select from the following (check as many as apply):

☐ Progress Notes
☐ Laboratory Tests
☐ Radiology reports
☐ Operative Notes
☐ Consultation Report from: _____
☐ Other _____

**INFORMATION RELEASED FROM:**

_____
Name of Company/Agency/Facility

_____
Street Address

_____
City, State, Zip code

**INFORMATION RELEASED TO:**

_____
Name of Company/Agency/Facility

_____
Street Address

_____
City, State, Zip code

**PURPOSE OF DISCLOSURE:**

☐ Referral to Specialist
☐ Insurance
☐ Legal Investigation
☐ Disability Determination
☐ Workers Comp
☐ Personal
☐ Other _____

I hereby authorize disclosure of the health information for the above patient. I authorize release to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency) Infections, Psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. This authorization is valid for 12 months form the date of the signature. I understand that I may cancel this request with written notification, but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons, or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual/guardian/POA Date