AUTHORIZATION TO DISCLOSE HIPAA PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the heath records of:

Client/Patient Name: _____ Date of Birth: ____/____/____ Soc. Sec. No.:____-___-____

I authorize the following person/organization to receive my Protected Health Information (PHI). This information may be disclosed to and used by the following individual or organization for the purpose of legal representation:

BRYON MIDDLEBROOK, P.C.
Bryon Middlebrook
308 N. Agassiz St.
Flagstaff, AZ 86001

INFORMATION TO BE RELEASED (check as applicable):

□ Allergy Records □ Consultations □ Developmental/Behavioral □ Discharge Summary
□ Drug/Alcohol Treatment □ Genetic Testing □ HIV/AIDS □ History & Physical
□ Hospital Records & Reports □ Immunizations □ Surgical Reports □ Laboratory Reports
□ Prescriptions □ Psychiatric □ Sexual Assault □ Treatment or Tests □ X-Ray Reports
□ Sexually Transmitted Disease □ Other Communicable Disease □ Other (Specify):

- OR –

☐ ENTIRE RECORD excluding the following (CIRCLE as applicable):
□ Sexually Transmitted Disease HIV/AIDS □ Other Communicable Diseases □ Genetic Testing
□ Developmental/Behavioral Health Care/Psychiatric Care □Treatment of Alcohol and/or Drug Abuse
□ Information about Child Abuse/Neglect

FOR THE FOLLOWING DATE(S) OF SERVICE:

From (MM/DD/YYYY): _____ / _____ / _____ To (MM/DD/YYYY): _____ / _____ / _____

I understand I have the right to revoke this authorization at any time. Unless otherwise revoked, this authorization will **expire one (1) year** from the date of signature. I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization. I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above to use or disclose my health information in the manner described above.

SIGNATURE: _____ DATE: _____