

## **HIPAA AUTHORIZATION FORM**

I, \_\_\_\_\_, hereby authorize the use or disclosure of my protected health information as described below:

### **1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

GDIT2 Medical Services is authorized to disclose the following protected health information to \_\_\_\_\_, at \_\_\_\_\_, Of \_\_\_\_\_, \_\_\_\_\_.

### **2. DESCRIPTION OF INFORMATION TO BE DISCLOSED**

The health information that may be disclosed is: \_\_\_\_\_

All past, present, and future periods of health care information may be shared.

### **3. PURPOSE OF THE USE OR DISCLOSURE**

The purpose of this use or disclosure is \_\_\_\_\_

### **4. VALIDITY OF AUTHORIZATION FORM**

This Authorization Form is valid beginning on \_\_\_\_\_ and expires on \_\_\_\_\_.

### **5. ACKNOWLEDGMENT**

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: \_\_\_\_\_ Date: \_\_\_\_\_