Erin Jacobson, ARNP
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AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth:_____

I authorize Erin Jacobson, ARNP and the named party below: To Obtain:_____To Exchange:_____To Disclose:_____
(please select AND initial)
Name:_____

Address:_____Phone:_____FAX**:**_____

The following health care information (**initial all that apply):**
_____All health care information in my medical record
_____Most recent progress notes/RX list/lab studies
_____Individualized Education Plan, school psychological testing, academic/behavior information within school
_____Other:_____

The purpose for the disclosure/communication is for: _____Coordination of Care Other**:**_____

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

_____Mental health Information____HlV/AlDS information_____Drug/alcohol diagnosis, treatment_____genetic testing

This authorization expires:_____One yr. from the date of my signature_____Termination of treatment with Erin Jacobson, ARNP

By my signature below, I hereby authorize Erin Jacobson, ARNP to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed. I understand that once Erin Jacobson, ARNP discloses my health information to the recipient, Erin Jacobson, ARNP cannot guarantee that the recipient will not re disclose my health care information to a third party. Furthermore, I understand that I may refuse to sign and/or revoke this authorization at any time and that such action will not affect my ability to receive health care benefits.

I have read and understand the terms of this authorization. By my signature below I knowingly and voluntarily authorize Erin Jacobson, ARNP to obtain/use and/or disclose my health information in the manner described above.

_____

Signature of Patient (age 13 and above) Date

_____

Signature of Legal Guardian (for children **under** age 13 years) or Legal Representative Date