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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME:_____

I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF INDIVIFUALLY INDENTIFIABLE HEALTH INFORMATION RELATING TO ME, WHICH IS CALLED "PROTECTED HEALTH INFORMATION" UNDER A FEDERAL HEALTH PRIVACY LAW, AS DESCRIBED BELOW:

Description of the information to be used or disclosed including the Dates of service(s):

_____

_____

Person or class of persons authorized to make use of the disclosed information:

(TO)_____

_____

Persons or class of persons to whom the use or disclosure may be made:

(FROM)_____

_____

The protected health information will be used and/or disclosed for the following purposes:

_____

_____

[ ] At the request of the patient
[ ] Other

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying the practice in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by the above practice before receiving my revocation.

SIGNATURE:_____ **DATE:**_____