AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Print Form

I authorize (insert name of person/entity disclosing information)**:**

to disclose a copy of the specific health information described below regarding (insert the individual's name):

(Describe below information to be used/disclosed)

To (recipient) :

For the purpose of (describe each purpose of disclosure or indicate that the disclosure is at the request of the individual):

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Mental Health information

_____ Genetic testing information

_____ Drug/alcohol diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION **You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.**

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to (contact person): _____

at (address of person/entity disclosing information): _____

and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires (insert either a date, or a specific event): _____

By: _____ **Date:** _____

(individual or personal representative)

Description of personal representative's authority: _____