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Authorization to Use and Disclose Protected Health Information

Authorization to release the health information of:

Patient Name:	*Date of Birth:*

This authorization is to release information to:

Name _____ Phone _____ Relationship: _____
Address _____City _____ St _____ Zip _____

Please indicate how you would like information disclosed: [ ] Pick-up in Office [ ] Mail [ ] Fax: _____
(Please include fax number)

Please check the boxes of the information you would like to have access to: [ ] All Records

[ ] Chart Notes [ ] History & Physical [ ] Discharge Summary [ ] Consultation
[ ] Operative Report [ ] Radiology Report [ ] Emergency Record [ ] Lab Report
[ ] Pathology Report [ ] Treatment Plan [ ] Psychiatric Record [ ] Immunizations
[ ] Alcohol/Drug Related Record [ ] Other _____

Term: This Authorization will remain in effect:

[ ] Until my child/children turn 18 years of age
[ ] Today Only
[ ] Other: _____

I understand that:

- once this office discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and sate law governing the use and disclosure of my health information.
- I may make a request in writing at any time to the Privacy Officer to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR 165.524. A fee of $ .10 per page may be charged for copying and postage fees may apply.
- my records are protected and cannot be disclosed without my written permission. *Alcohol/drug treatment records are protected by federal rule 42 CFR, part 2.
- this Authorization will remain in effect until the Authorization expires or I provide a written notice of revocation to the office.

To be used if facility requests this authorization:

- I may refuse to sign or may revoke this Authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of "this facility's" treatment of me.

If I have questions about disclosure of my health information, I can contact the Privacy Officer.

Printed name of Patient/Patient Representative if a minor _____

Signature _____ Date _____

**Copy available upon request