

Patient Label

Patient Authorization

To Permit Use and Disclosure of Health Information

Patient Name: _____ DOB (mm/dd/yyyy): ____/____/____

I am either the patient named above or the patient's legally authorized representative.

By signing this form, I hereby authorize this facility to use or disclose to:

_____ **the following**
(Person to whom requested use or disclosure would be made)

protected health information (be specific and include dates of service or procedure, if applicable):

Authorized information will be used and/or disclosed for the following purposes:

- _____ At the request of the individual
- _____ Other (please list each purpose): _____

I understand that I may revoke this Authorization at any time, except to the extent that action has been taken in reliance on it (or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy). If I revoke this Authorization, I must do so in writing.

I understand that I may refuse to sign this Authorization. I also understand that my treatment will not be conditioned on receiving my signature on this Authorization. I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

This Authorization expires automatically upon date or event that relates to the patient or the purpose of the Authorization.

Signature of Patient or Legal Representative

Date

If Legal Representative, please explain authority to act on behalf of the patient:

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