



**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize: \_\_\_\_\_ to use and/or disclose protected health information (PHI) about me to: \_\_\_\_\_

(Name and Address of Person/Organization Receiving Information)

\_\_\_\_\_  
\_\_\_\_\_

for the purpose of: \_\_\_\_\_.

The treatment dates covered by this authorization are from: \_\_\_\_\_ to \_\_\_\_\_.

The information to be released is confined to the following:

<input type="checkbox"/> Physician Notes	<input type="checkbox"/> EKG/EEG	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Copies of records from: _____
<input type="checkbox"/> Procedure Reports	<input type="checkbox"/> Consultations	<input type="checkbox"/> History and Physical	_____
<input type="checkbox"/> Laboratory Data	<input type="checkbox"/> Verbal Communication	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Radiology Reports			_____ which were added to my records at this institution for my continuing care needs.

*Psychotherapy notes cannot be re-released by this institution.*

The clinic will \_\_\_ will not \_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

The consent will automatically expire 90 days from the date signed, or on \_\_\_\_\_.  
(Expiration date or Defined Event)

I understand that I do not have to sign this consent to receive treatment from this clinic. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, to the Privacy Officer of the clinic, except to the extent that action has already been taken in reliance upon this authorization.

**THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date of Birth of Patient

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date and Time Signed