AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____

To: _____

_____

_____

1. My Authorization

You may use or disclose the following health care information (check all that apply)

__All my health information maintained by the above-named practice.

__My health information relating to the following treatment or condition: _____

__My health information for the date(s) _____

__Other_____

You may disclose this health information to:

_____ **Phone:** _____

_____ **Fax:** _____

_____

Purpose for Need of Disclosure: (Check applicable categories)

__Further Medical Care __Coordinating Care for Dependent/Spouse __Insurance Eligibility/Benefits

__Claims Resolution __Other (Please specify_____

This authorization will expire on (date or event) _____If I fail to specify an expiration date, or event, this authorization will expire (12) months from date on which it was signed.

2. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above named practice based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

Fill out a revocation form. The form is available from the office

Write a letter to the Office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship (legal guardian, personal representative