Authorization to Use/Disclose Protected Health Information

I authorize: _____
(Name of individual/clinic who is disclosing health information)

To use and disclose health information described below regarding:

_____
(Name of Patient) **(Date of Birth)**

To be sent to: _____
(Name and address where information should be sent)

Type of information to be disclosed:

____ Office Visit Notes for last 2 years
____ Current Medication List
____ Lab and test results for last 2 years
____ Other – Please describe_____

For the purpose of: ____ Patient Care ____ Other - please describe_____

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
____ Genetic Testing Information
____ Mental Health Information
____ Alcohol/Chemical Dependencey 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 and specifically require my authorization prior to redisclosure.

PATIENT 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to the Clinic Manager, and state you are revoking this authorization.

I have read this authorization and I understand it.

Signature: _____ Date: _____

Unless revoked, this authorization expires: _____
(Insert applicable date or event)