# AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize _____ to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Covering the period(s) of health care:
From _____ to _____

Information to be disclosed:
☐ Complete health record(s)
**OR**
Select from the following (check as many as apply):

☐ Discharge Summary
☐ History and Physical Examination
☐ Consultation Reports
☐ Progress Notes
☐ Laboratory Tests
☐ X-ray reports
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
☐ Mental health care or services
☐ Psychotherapy Notes
☐ Treatment for alcohol and/or drug abuse
☐ Photographs, videotapes, digital or other images
☐ Other (please specify) _____

**This information is to be disclosed to: _____**

**Address: _____Fax:_____ Telephone: _____**

The patient or the patient's representative must read and initial the following statement:

I understand that unless earlier revoked, this authorization will expire in 12 months. Initials: _____
**(*Form MUST be completed before signing*)**

_____ Date_____
Signature of Patient or Representative

_____ Relationship of Representative to Patient_____
Print Name

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***