

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected Health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health information to the following person(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective dates for this authorization ___/___/___ through ___/___/___
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature of Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date