AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION
HEALTH INFORMATION AND/OR EMPLOYMENT RECORDS

A copy of this authorization will be considered as valid as the original.
Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize: _____
Name of Disclosing Party

_____
Address

_____
City State Zip Code

To disclose to: _____
Name of Receiving Party

_____
Address

_____
City State Zip Code

Records and Information pertaining to

_____ _____ _____
Name of Patient (list other names used) Medical Records # Date of Birth

_____ _____
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(date) Or for one year from the date of signature.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS:

☐ Medical Information _____ Initials

☐ Psychiatric Information

☐ Drug/Alcohol Information

_____ Signature Date

☐ Results of HIV Blood Test

_____ Signature Date

☐ Other Health Information (_____Specify below)

☐ Employment Records _____ Initials

Specify the records to be disclosed:

_____

_____

The requester may use the health information authorization on this form for the following purposes only:

_____

_____

Signature:_____ Date:_____