AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:_____ **Date of Birth:** _____
Last **First** **Middle**

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider (Please insert name of provider) _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information _____. Address or Fax # of the recipient or where my health information should be delivered:
_____.

Purpose: I understand that the specific purpose of this Authorization is
_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ All of my health information described above except for the following:
  _____.
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)_____.

Term: This Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 200__.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**