



Patient Authorization for Use and Disclosure Of Protected Health Information

Patient Name: _____ Date of Birth: _____

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

(Name, address, and phone/fax of entity to receive this information)

This authorization permits _____ to use and/or disclose the following identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of service, types of services, level of detail to be released, origin of information, etc.):

This authorization will expire on _____ (please allow at least 1 week)

When my information is used or disclosed pursuant to this authorization, it may subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon authorization.

Signed by: _____
SIGNATURE of Patient or Legal Guardian

Relationship to Patient

Patient Name (if different from above)

Date

PRINT Patient Name or Legal Guardian

Signature of Witness