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AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: _____Patient SSN: _____Patient DOB: _____

Patient/Guardian name: _____ Patient/Guardian address: _____

Patient/Guardian phone #: _____City/State/Zip_____

I hear by authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

NAME OF INDIVIDUAL/ FACILITY / COMPANY TO **RECEIVE** PHI

Name_____

Address_____

City/State/Zip_____

Phone #_____Fax_____

NAME OF INDIVIDUAL/ FACILITY / COMPANY TO **DISCLOSE** PHI

Name_____

Address_____

City/State/Zip_____

Phone #_____Fax_____

Request to receive information Electronically:

I would like my information released to me in the following electronic format:

- Unsecure e-mail, please send to the following email:_____
  I understand that my information could be viewed by others without the security protections afforded by encryption.

Information authorized for use of disclosure or to be obtained:

- All medical information concerning this patient.
- Medical information for this patient compiled between_____and _____
- Only: _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

( ) Insurance **( )** Continued treatment **( )** Legal **( )** At the request of the patient or patient's representative **( )** Other(specify)

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:
- I release the entitles listed above, their agents and employees from any liability in connection with ethical use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer Protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements
- I have the right to inspect the health information to be released and I may refuse to sign the authorization?
- Unless the purpose of this authorization is to determine payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient/Parent/Representative Date

_____ _____

Description of Legal Representative's Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure amount healthcare providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of the identifying information is authorized by you, by an order of the court or the Department of health or by law.