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Authorization to Disclose Protected Health Information

Protected Health Information means information that can identify you that relates to your health, the provision of care or your payment for health care services.

Protected Health Information may be used and disclosed without your consent for purposes of treatment, payment or health care operations.

This authorization is NOT consent to treatment.

This is ONLY an authorization to use and disclose Protected Health Information for other purposes.

Treatment will NOT depend on your signing this authorization.

I AUTHORIZE –

_____
(Name of Covered Entity)

To disclose, as specified below, Protected Health Information regarding –

_____ _____
(Name of Patient) (Date of Birth)

TO –

_____
(Name of Person or Place that you want to receive your health information)

_____
(Address of Recipient of Information)

_____
(Fax Number) (Phone Number)

1. This Authorization pertains to Protected Health Information from the following time periods:

   ☐ _____to _____
   (Insert Dates)

   ☐ All past, present, and future periods

2. I Authorize:
   - ☐ The disclosure of **all my Protected Health Information for the above time period** (which may include records relating to treatment for mental illness and/or alcohol/drug abuse). OR
   - ☐ The disclosure of **all my Protected Health Information for the above time period EXCEPT** as noted below:
     - ○ Do not disclose psychiatric/psychological/mental health treatment records.
     - ○ Do not disclose alcohol/drug abuse treatment records.
     - ○ Do not disclose other records (identify below):

     _____

3. Authorization is permitted for these reasons (Check all that apply):
   - ☐ Insurance/Disability
   - ☐ Litigation
   - ☐ Personal Reasons
   - ☐ Continued Care
   - ☐ Other (specify) _____

4. This Authorization shall be in force and remain in effect until_____ at which time this Authorization expires. (Date or Event)
   (This authorization can remain in effect for no more than one (1) year.)
   (If no date or event is provided, this authorization will expire in one (1) year.)

5. I understand that I can revoke this Authorization at any time by giving a written request to: _____
   (Name of Covered Entity)

6. I understand that my treatment will not depend on whether I sign this Authorization.

7. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

8. If signing for Patient, I represent I have proper authority to sign this document on behalf of the person identified above.

_____ _____
Signature of patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient