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AUTHORIZATION FOR USE AND DISCLOSURE OF IDENTIFYING HEALTH INFORMATION

Patient's Name: _____

Patient's Number: _____

Patient's Address: _____

Patient's Phone Number: _____

I authorize the release of health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released:

_____

2. Description of persons authorized to make requested use or disclosure: [List the name or specific identification of the person or classes of persons]

_____

_____

3. To whom may the information be released [name(s) or class(es) of recipients]:

_____

_____

_____

4. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

_____

5. Expiration date or expiration event relating to the individual or purpose for the release:_____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office address listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law limits this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: _____

Patient's Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Source of Authority

_____