AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: _____

_____

to disclose a copy of the specific health information described below regarding:

Patient Name:_____**DOB**_____

consisting of: (Describe information to be used/disclosed)

_____

_____

to: (Name and address of recipient or recipients)

_____

_____

for the purpose of: (Describe purpose of disclosure.)

_____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

- _____ **HIV/AIDS information**
- _____ **Mental health information**
- _____ **Genetic testing information**
- _____ **Drug/alcohol diagnosis, treatment, or referral information**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is when the health care services are solely for the purpose of providing health information to someone else and the autorization is necessary to make that disclosure.
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.
To revoke this authorizaton please send a written statement indicating that your are revoking this authorization to:

_____
(Contact Person)

at: _____
(Address of person/entity disclosing information)

SIGNATURE:
I have read this authorization and I understand it. Unless revoked, this authorization expires_____
(Insert either applicable date or event)

(Print)_____ _____
(Print Patient's Name) ***(Patient's date of birth)***

Sign: X_____ **Date:** _____
(Patient or personal representative -- Signature)