AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

The information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.
Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Patient Last Name	Patient First Name	Middle Name
Smith	Mary	A
Nickname/Maiden Name	Birth Date: 1/1/1900	Telephone: (xxx) xxx-xxxx Okay to leave detailed message? Yes No
Patient's Mailing Address: Street/P.O. Box City, State, Zip Code		

Healthcare Provider to **Release** Information:		
Name: List who should send the information		
Address		
City	State	Zip
Phone	Fax	

Person or Agency to **Receive** Information:		
Name: List who will get the information		
Address		
City	State	Zip
Phone	Fax	

Recipients address and phone number are required. Fax is optional.

Purpose of release: Add the reason records are needed

If such information exists, I authorize the disclosure of:

☐ the entire medical record **or**

☐ the following specific documents, dates of service, and/or information about the following injury/illness/disease:

The patient can select "x" the entire medical record or "x" for specific documentation and/or date ranges.

The following items **must be initialed** to be released:

_____HIV-positive test results and HIV diagnosis
_____Mental health information and/or records
_____Genetic testing information and/or records
_____Other sexually transmitted diseases
_____Drug/alcohol diagnosis, treatment, or referral information. Per Federal regulations, describe how much and what kind of information is to be disclosed: _____

If the patient would like sensitive/ specially protected information sent, they will initial the spaces for each item they want sent.

Federal or state law may restrict redisclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

The only circumstance when refusal to sign means the patient will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will expire in one year from the date of signing or on _____, whichever is later. If this line is blank the authorization is valid for 1 year after the signature date.

_____ _____
Signature of Patient or Patient's Legal Representative — Date

_____ _____
Print Name (If other than the patient, proof of authority is required.) — Relationship to Patient

If this form is signed by the patient's health care representative, as defined by HIPAA, valid supporting documentation must accompany this authorization.

(5/25)
A copy of this signed form will be provided to the patient or personal representative.

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