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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I HEARBY AUTHORIZE USE OR DISCLOSURE OF THE INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ SOCIAL SECURITY#_____
STREET

_____ TELEPHONE#(___)_____
CITY STATE ZIP

FROM: (INDIVIDUAL OR ORGANIZATION AUTHORIZED TO MAKE DISCLOSURE)

_____
NAME

_____
ADDRESS

_____
PHONE FAX

TO: THIS INFORMATION MAY BE DISCLOSED TO & USED BY THE FOLLOWING

_____
NAME

_____
ADDRESS

_____
PHONE FAX

PURPOSE OF REQUEST: { } PATIENT REQUEST { } TRANSFER OF CARE { } SECOND OPINION
{ } RELOCATION { } LIFE INSURANCE APPLICATION { } DISABILITY APPLICATION

SENSITIVE INFORMATION: I UNDERSTAND THAT THE INFORMATION IN MY RECORD MAY INCLUDE INFORMATION RELATING TO SEXULLY TRANSMITTED DISEASES (STD), ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES OR TREATMENT FOR ALCOHOL AND DRUG ABUSE._____YOUR INITIALS
REDISCLOSURE: I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR REDISCLOSURE AND THAT THE INFORMATION MAY THEN NOT BE PROTECTED BY FEDERAL CONFIDENTIALLY RULES._____YOUR INITIALS **RIGHT TO REVOKE:** I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT MY REVOCATION MUST BE WRITING. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION ALREADY RELEASED BASED ON THIS AUTHORIZATION._____YOUR INITIALS I UNDERSTAND THAT I MAY INSPECT OR OBTAIN A COPY OF THE INFORMATION TO BE DISCLOSED.___YOUR INITIALS. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE OR CONDITION:
IF I DO NOT SPECIFY A DATE, EVENT OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS

YES	NO	
{ }	{ }	PHYSICIAN NOTES
{ }	{ }	LAB RESULTS
{ }	{ }	PATHOLOGY/ PAP REPORTS
{ }	{ }	ULTRASOUND REPORT
{ }	{ }	MAMMO REPORTS
{ }	{ }	SENSITIVE INFO (HIV,STD,AIDS)
{ }	{ }	OTHER (PLEASE SPECIFY)

DATE:_____

SIGNATURE OF PATIENT:_____