PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ (Patient Name) is requesting the release of health information described below to:

_____
Name or other specific identification of person(s) or department/Name of organization to receive disclosure

_____
Address and phone # of organization receiving disclosure

The purpose(s) of the use or disclosure is:
_____ At the request of the individual
_____ Other (if other, please provide explanation) _____

Information or medical data that may be disclosed includes any and all information necessary to discuss payment of account.

I authorize _____ and any appropriate representative thereof to disclose any and all health information listed above.

CONDITIONS AND NOTIFICATIONS

This authorization for release of information expires 12 months from the date of patient's signature unless otherwise specified (_____). (expiration date or event)

I realize I may revoke this authorization in writing at any time; however, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. I also realize I may inspect or request a copy of the health information to be used or disclosed, consistent with federal law and am aware that there may be a copying fee associated with this request to cover labor and supplies used to reproduce medical records.

I understand that I do not have to sign this authorization in order to receive treatment from _____ and that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION