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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I Hereby Authorize: _____
NAME OF DISCLOSING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

to disclose to: _____
NAME OF RECEIVING PARTY

_____
ADDRESS

_____
CITY STATE ZIP

Records and Information Pertaining to:

_____ _____ _____
NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

_____ _____
ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of the signiture.
DATE

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

☐ **MEDICAL INFORMATION** _____ INITIAL _____ DATE

☐ **PSYCHIATRIC INFORMATION** _____ INITIAL _____ DATE

☐ **RESULT OF HIV BLOODTEST** _____ INITIAL _____ DATE

☐ **DRUG/ALCOHOL INFORMATION** _____ INITIAL _____ DATE

☐ **OTHER HEALTH INFORMATION** _____ INITIAL _____ DATE

Specify the records to be disclosed: _____

_____

_____

Patient Signature: _____ **Date:** _____