

**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 signature. DATE

**REVOCACTION:** 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.

**REDISCLASURE:** 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**       **PSYCHIATRIC INFORMATION**       **RESULT OF HIV BLOODTEST**

\_\_\_\_\_  
INITIAL      DATE      INITIAL      DATE      INITIAL      DATE

**DRUG/ALCOHOL INFORMATION**       **OTHER HEALTH INFORMATION**

\_\_\_\_\_  
INITIAL      DATE      INITIAL      DATE

Specify the records to be disclosed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_