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Authorization to disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Medical record Number or SSN: _____

The following person or entity is authorized to disclose my medical records:

Name: _____

Address: _____

_____

The disclosure will be made to the following person or entity:

Name: _____

Address: _____

_____

For the purpose of:

_____

_____

The type and amount of information to be used or disclosed:

- **Medication List**
- **Most Recent History and Physical**
- **Consultation Reports** **From (Doctor's Name(s)** _____
- **Laboratory Results** **From (date)** _____ **to (date)** _____
- **Operative Reports** **From (date)** _____ **to (date)** _____
- **Psychotherapy Records** **From (date)** _____ **to (date)** _____
- **X-Ray and Imaging Reports From (date)** _____ **to (date)** _____
- **Entire Records**

Other: _____

I hereby authorize the use or disclosure of information about the above named individual and I understand that:

1. This information about me is protected under federal law.
1. I may refuse to sign the authorization.
2. I have the right to revoke this authorization in writing.
3. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
4. Unless I revoke this authorization, it will expire on the following date ____/____/____, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
5. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.
6. Treatment or payment will not be based on my signing this authorization.
7. I will receive a copy of this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____