AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone _____

By signing this form, I authorize _____ (*name of provider or program authorized to use and disclose information ("Provider")*) **to use and disclose my medical information to:**

Name _____

Address _____ City _____ State _____ Zip _____

FOR THE PURPOSE OF: ☐ Coordination of Care/Treatment ☐ At Request of Patient ☐ Other _____

INFORMATION TO BE DISCLOSED:

☐ Provider Notes of Medical History, Examination Progress or Discharge
☐ Tests and Results
☐ Immunizations
☐ Radiology Reports
☐ Laboratory Reports
☐ Entire Record (specific justification) _____
☐ Surgical Reports
☐ Hospital Records Including Reports
☐ Allergy Records
☐ Prescriptions
☐ Consultations
☐ Other (Specify): _____

Date(s) of Service: _____ **to** _____

I DO <u>NOT</u> WANT THE FOLLOWING INFORMATION DISCLOSED:

☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AIDS ☐ Alcohol/Drug Abuse ☐ Genetic Information

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this Authorization and my Provider will not condition treatment or payment upon my signing of this Authorization. However, if I do not sign this Authorization, I understand that my other health care providers may not have access to all my relevant medical information in providing me with care.

Right to Revoke Authorization. I understand that I have a right to revoke this Authorization at any time by submitting my revocation in writing to my Provider. I understand that my revocation will not apply to information that has already been released in reliance on this Authorization.

Re-disclosure of Information by Recipient. I understand that if my medical information is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the person(s)/organization(s) receiving my medical information and no longer protected by applicable privacy laws. However, if the disclosure includes my alcohol or drug abuse treatment information protected by federal law 42 C.F.R. Part 2, the recipient will be prohibited from further disclosing that alcohol or drug abuse treatment information except as expressly permitted by law.

Right to Receive a Copy of This Authorization and My Medical Information. I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I also have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization.

EXPIRATION: This Authorization expires six weeks after the end of my pregnancy.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Date

If signed by a Legal Representative, complete the following:

1. The individual is: ☐ a minor ☐ legally incompetent or incapacitated
2. Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.

_____ _____
Signature of Witness Date