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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Client Name:_____ Date of Birth:_____

I hereby authorize the use or disclosure of the PHI described below to be provided to or obtained by the following:

Name and address of party receiving PHI:

_____
_____
_____

Name and address of party disclosing PHI:

_____
_____
_____

Information authorized for use or disclosure, or to be obtained (examples include History & Physical, Discharge Summaries, Progress Notes, Treatment Summary, etc.):

_____

The information will be obtained, used, or disclosed for the following purposes only (examples include Insurance Purposes, Continued Treatment, Legal Reasons, Verification for Emotional Support Animal, etc.):

_____

I understand that I may revoke this authorization in writing at any time as provided in the Notice of Privacy Practices, except revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be eighteen (18) months from date of signature or upon occurrence of the following event:_____. I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of PHI. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization. Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility of benefits on obtaining this authorization. I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and Human Immunodeficiency Viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions and/or substance abuse.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Client's Signature _____ Date _____

Signature of Personal Representative _____ Date_____

Description of Personal Representative's Authority to Act for Client_____

NOTICE OF RIGHTS: Information in your medical records that you have or may gave a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.