AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION/ RESTRICTION OF PHI

Patient Name:_____ Date of Birth: _____

Person Authorized to Receive Information:
By signing this authorization, I authorize _____to use and/or disclose certain protected health information (PHI) they have about me to the following person/ entity(s):

_____
Name of person or entity/ relationship

_____
Name of person or entity / relationship

I hereby authorize the release of the following to the person/entity(s) listed above: *(check all that apply)*

- ☐ **My Complete health record** (which includes info of ALL PHI check boxes below)

- ☐ History and Physical Exams
- ☐ Lab Report
- ☐ Consultation Report
- ☐ Mental Health Records
- ☐ Communicable disease
- ☐ My (patient) personal Contact information
- ☐ My (pt.) spouse's Contact information
- ☐ Other (please specify): _____
- ☐ Appointment and Visit Notes
- ☐ X-Ray Report
- ☐ Prescription/ Pharmacy Records
- ☐ Alcohol/ Drug Abuse Treatment
- ☐ HIV/ AIDS (inc. testing related info)
- ☐ Any Occupation/ Employer Information
- ☐ Hospital notes

The information will be used or disclosed for the following purpose: *(check all that apply)*

- ☐ Continuing Care
- ☐ Legal
- ☐ School
- ☐ Other: _____
- ☐ Research
- ☐ Marketing
- ☐ Second Opinion
- ☐ Workers Compensation
- ☐ Insurance Company

Expiration Date of Authorization:
This authorization will expire on_____(date or defined event). If no expiration is provided this authorization will remain in effect unless revoked or terminated by the patient or patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to the Privacy Officer or other authorized representation in our office.

By signing below, I acknowledge that I have read and understand:

- That when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- The care center may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
- That I do not have to sign this authorization in order to receive treatment and by signing below,
- A photocopy of this authorization will be considered as valid as the original (copy to be provided upon request.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Date

_____ _____
Print Name of Patient or Legal Guardian — Relationship to Patient