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### Authorization for Use and Disclosure of Protected Health Information

I, \_\_\_\_\_ Date of birth: \_\_\_\_\_, authorize the disclosure of my protected health information. I understand that this authorization is voluntary and made to confirm my direction.

I hereby authorize:

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

To disclose my protected health information as indicated below to:

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Information to be released: **(Please initial)**

\_\_\_\_\_ All health care information in my health record.

\_\_\_\_\_ Health care information relating to the following treatment or condition: \_\_\_\_\_

\_\_\_\_\_ Health care information in my health record for the date(s): \_\_\_\_\_

\_\_\_\_\_ The following specific report/results: \_\_\_\_\_

I **specifically** authorize the release of information relating to: (Please Initial)

\_\_\_\_\_ Substance Abuse (including alcohol and prescription medication)

\_\_\_\_\_ Mental Health or behavioral health

\_\_\_\_\_ HIV related information (AIDS related testing)

**Signature of Patient/Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Optional:** I request the medical records in the following electronic format. \_\_\_\_\_  
ie. Emailed through the patient portal, on a disc, on a flash drive (additional cost will apply for a flash drive provided by us)

**Purpose of disclosure:**

\_\_\_\_\_ Changing Physicians      \_\_\_\_\_ Disability Determination      \_\_\_\_\_ Personal Use

Other (Specify) \_\_\_\_\_

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

**Initial each line**

\_\_\_\_\_ I understand the expiration date of this authorization is **90 days** from the date signed unless otherwise stated here \_\_\_\_\_.

\_\_\_\_\_ I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

\_\_\_\_\_ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

\_\_\_\_\_ I understand that I may be required to pay the cost of preparing and sending copies except for uses and disclosures for the purpose of treatment, payment, and operations. The fee will not exceed current state limits.

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and Relationship to patient