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**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and no longer protected by federal privacy regulations.

Patient Name: _____

Patient SSN: _____

Patient DOB: ____/____/____

Person/organizations providing the information:

Persons/organizations receiving the information:

Disclose the following PHI for treatment dates _____ to _____

- Face Sheet
- History & Physical
- Emergency Room Record
- Lab Report(s)
- Clinic Notes
- Consultation Reports from
(please supply physician's name): _____
- Diagnostic Procedure Reports
- X-ray Report(s)
- Other (please describe): _____

Purpose of Use or Disclosure

This information for which I'm authorizing disclosure will be used for the following purpose:

- Medical Care Legal Insurance Personal Sharing with other health care providers as needed.

This authorization shall expire upon this date: _____
 **If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to _____. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure or the protected health information as stated.

Signature of Patient/Legal Representative

Printed Name of Patient

Relationship to the Patient

Date