PATIENT AUTHORIZATION
To Permit Use and Disclosure of Health Information

Patient Name:_____ **Date of Birth:**_____

I am either the patient named above or the patient's legally authorized representative.
By signing this form, I hereby authorize this facility to use or disclose to:

_____
Person to whom requested use or disclosure would be made

Myself _____ Mailing address: _____

_____

The following protected health information (be specific and include dates of service, if applicable):

_____

Authorized information will be used and/or disclosed for the following purposes:

_____ At the request of the individual

_____ Other (please list each purpose) _____

I understand that I may revoke this Authorization at any time, except to the extent that action has been taken in reliance on it (or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy). If I revoke this authorization, I must do so in writing.

I understand that I may refuse to sign this Authorization. I also understand that my treatment will not be conditioned on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

This Authorization expires automatically upon _____
Date or event that relates to the patient or the purpose of the Authorization

_____ _____
Signature of Patient or Legal Representative Date

If Legal Representative, explain authority to act on behalf of the patient :

_____