Authorization To Use or Disclose My Health Care Information

Granted to:(name of provider or organization):_____

Patient name: _____ **Date of birth:** _____

Previous name: _____ Address: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment(s) or condition(s):

_____

☐ Health care information in my medical record for the date(s):

_____

☐ Other (e.g., X rays, bills), specify date(s):

_____

You may disclose this health care information to

Name (or title) and organization_____

Address: _____City: _____State _____Zip_____

Reason(s) for this authorization (check all that apply):

☐ Planning the treatment of any terminal illness from which I may suffer

☐ Planning the treatment of other conditions from which I may suffer

☐ Other (Specify)_____

This authorization ends: ☐ in 90 days from the date signed ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization unless I wish to grant my health care representative or others named herein to have access to information about my condition and medical care for the purpose of assisting in the planning of the treatment that I could be offered.

I may revoke this authorization in writing. If I do, it would not affect any actions already taken by (name of practice or health care facility) based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- ☐ Fill out a revocation form if a form is available from the (practice/health care faciity
- ☐ Write a letter to the (practice/health care faclity

Once health care information is disclosed, the person or organization that receives it may re-disclose it. I understand that privacy laws may no longer protect this information.

_____ _____ _____
Legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)