Authorization to Use or Disclose Health Information

Patient Name:_____

Health Record Number:_____

Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

- ☐ entire record
- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☐ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed):
- ☐ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ☐ consultation reports from (please supply doctors' names):
- ☐ other (please describe):

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name:
Address:

Name:
Address:

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

- ☐ my personal records
- ☐ sharing with other health care providers as needed
- ☐ other (please describe):

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire _____(insert date or event). If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____

Signature of patient or legal representative

_____

Date

If signed by legal representative, relationship to patient _____

_____

Signature of witness

_____

Date

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure

Source: American Health Information Management Association