Authorization for Use and Disclosure of Patient Health Information

Patient Name: ____

Date of Birth: ____

Phone Number: ____

Patient Address: ____

- I **authorize** ____, the "Clinic", to use and/or disclose the following health information from my medical record: _____________________________________
  ____
  (describe information, including dates and types of conditions)

- I specifically authorize the Clinic to disclose the types of information selected below:
  - Information relating to care and treatment for mental health conditions
  - Information relating to care and treatment for drug and alcohol abuse
  - Information relating to HIV testing, infection status, or care and treatment for HIV/AIDS
  - Information relating to genetic testing

- The above information may be **disclosed to**: ____
  ____
  (name of person/facility and complete address)

- The disclosure is for the purpose of: ____
  (if no purpose is stated, the disclosure is made at my request)

- This Authorization expires on the following date or event: ______________________________ If left blank, this Authorization will expire one (1) year from the date this Authorization is signed.

- I understand that I have the right to revoke this Authorization at any time, except to the extent that the Clinic has already taken action in reliance on this Authorization. I may revoke this Authorization by submitting my revocation in writing to the Clinic at the address stated above.

- I understand that the information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be subject to protection under the Clinic's policies and procedures or federal laws protecting the privacy of patients' health information.

- I understand that the Clinic does not condition my treatment on my signing this Authorization and that I may refuse to sign this Authorization. However, if the Clinic is providing health care solely to create information for disclosure to the third-party named above, the Clinic will not provide health care unless I sign this Authorization.

____

Signature   Date

If someone other than the Patient signs this Authorization:

Printed Name: ____________________________________

Relationship to Patient:
- Legal Guardian
- Parent
- Other (please specify): ________________________

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