

Authorization for Disclosure of Protected Health Information
(Not to be used for purposes of marketing or sale of PHI)

Patient Name (print):		Birth Date:	Date of Service:
Street Address:	City	State	Phone number:

Persons/Organizations Authorized to Release Information: _____ (the "Covered Entity")

Persons/Organization to Receive the Information: (the "Recipient")

Name (or title) and organization:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

I hereby authorize the Covered Entity named above to release the following health information to the Recipient:

- All of my health information in the Covered Entity's possession (clinical documentation and billing information)
- Clinical Documentation only in the Covered Entity's possession
- Billing information only in the Covered Entity's possession
- Other (Please describe: may include date restrictions or other limitations) _____

Purpose of Disclosure: _____

Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose

This authorization will expire on the following: (Fill in date or the Event but not both)

Date: _____ **Event:** _____

My Rights

I understand that:

- I have the right to revoke this authorization, in writing, at any time. In order to revoke this authorization, I must do so in writing and send it to the appropriate Covered Entity.
- The revocation will only be effective from the date it is received by the provider and will not apply retroactively. Uses and disclosures already made based upon my original permission cannot be taken back.
- It is possible that information disclosed based on this authorization may be re-disclosed by the recipient; once disclosed, the information may no longer be protected by the HIPAA Privacy Standards.
- I understand the Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I have the right to refuse to sign this authorization.
- I may receive a copy of this authorization after I have signed it upon request. A copy of this authorization is as valid as the original.

Not for Marketing or Sale

This authorization does not authorize the Covered Entity to sell the information or to use the information for marketing purposes.

Signatures

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

Signature of Patient/Patient's Representative:	Date:
Print Name of Patient or Patient's Representative, if applicable:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Representative (Describe authority and provide documentation): _____ _____