

# Authorization to Use or Disclose Health Care Information

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

## 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 or condition: \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X-rays, bills), specify date(s) : \_\_\_\_\_

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)  Sexually transmitted diseases
- Psychiatric disorders/mental health  Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization or class of persons: \_\_\_\_\_

Address (optional): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

- at my request  check only if [practice/facility] requests the authorization for marketing purposes
- other (specify) \_\_\_\_\_  check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

**This authorization ends:**

- on (date): \_\_\_\_\_  when the following event occurs: \_\_\_\_\_
- in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

## II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, 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. A form is available from the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

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

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)