AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize ____ to disclose protected health information ("PHI") from the health records of:
Patient name: ____
Address: ____
Phone number: ____
Patient medical record number [Or DOB]: ____________________

I authorize PHI from __________[date] to _____________ [date] to be disclosed to ____ at ____ [address]; ____________ [phone number if known]; ____________[fax number if known].

Specific description of the information to be disclosed:

______ Discharge Summary
______ Progress Notes
______ History and Physical Exam
______ Operative Reports
______ X-ray Reports
______ Lab Tests
______ Other (specify) ______________________________

Specific description of the purposes of the disclosure:

______ Continued Patient Care
______ Workers' Compensation
______ Insurance Coverage or Payment for Care
______ Other (specify) ______________________________

-OR-

______ The disclosure is at my (the patient's) request.

I authorize the provider to use or disclose information related to (check all that apply):

______ AIDS/HIV and other Communicable Disease
______ Behavioral Health Care/Psychiatric Care/Mental Health Information
______ Alcohol and/or Drug Abuse Treatment
______ Genetic Testing Information

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the Clinic's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to the clinic.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

______________________________	______________________
Signature of Patient	Date
______________________________	______________________
Signature of Legal Representative	Relationship to Patient or Description of Authority to Act for Patient