



AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

- I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- Patient Name _____ Date of Birth _____
Address _____
Street City State Zip Code
- Information to be disclosed to _____
Name _____
Street City State Zip Code
- Disclose the following information for treatment dates _____ to _____ OR
_____ Complete Records _____ Laboratory _____ Pathology
- The above information is disclosed for the following purposes:
_____ Medical Care _____ Personal _____ Legal _____ Insurance _____ Other
- I understand I may revoke this authorization at any time by requesting such of the above referenced physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.
- This authorization expires on (upon) _____
Date or Event

Signature of patient or legal representative

Date

Printed name of patient or patient's representative

Relationship to patient or authority to act for patient

This authorization shall be deemed invalid unless all numbered entries are completed