## Authorization for _____to Use or Disclose My Health Care Information

Name of practice

Patient name:_____ Date of birth: ___/___/___

Previous name:_____

### *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 relation 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 disorder/mental health

___ Drug an / or alcohol use

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

Name (or title) and organization:_____

Address:_____ City:_____State:_____ Zip:_____

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

___ at my request

___ check only if _____ _____requests the authorization for marketing purposes

NAME OF PRACTICE

___ check only if _____ _____will be paid or get something of value for

NAME OF PRACTICE

providing health information for marketing purpose

___ other (specify)_____

**This authorization ends: (*This document does not permit disclosure of health information created more than 90 days after the date it is signed.)***

___ in 90 days from the date signed ____ on (date): ____/____/____

___ when the following event occurs: _____

(no longer than 90 days from date signed)

*** 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 _____ based upon this authorization. I may not be able to revoke this

NAME OF PRACTICE

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 _____. Or

NAME OF PRACTICE

write a letter to _____

NAME OF PRACTICE

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)

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