Authorization for Disclosure of Protected Health Information

To:_____

_____

(the "Keeper of the Records").

I,_____, hereby authorize you to disclose all information or records concerning me, including any medical information ("Protected Health Information" as defined under the federal HIPAA privacy regulations), consisting of information, opinions, reports, charts, x-rays, tests, test results, studies, progress notes, medical inquiry forms, and any and all other records of any kind concerning my treatment or evaluation, including all information relating to the testing, diagnosis, or treatment for drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions and HIV/AIDS-related conditions, to _____ _____ or its representatives.

This Protected Health Information will be disclosed for the purpose of _____ _____.

I understand that I have the right to refuse to sign this Authorization and that my treatment may not be conditioned on the signing of this Authorization.

I understand that I may revoke this Authorization at any time by providing a signed, written notice of such revocation to the Keeper of the Records. My revocation of this Authorization will be effective immediately and my Protected Health Information can no longer be disclosed by the Keeper of the Records, except to the extent that it has already taken action in reliance upon my authorization.

I understand that the information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

This Authorization, unless revoked earlier, shall remain in effect until _____ _____.

A photocopy of this Authorization shall have the effect of an original.

Date of Birth:_____ Social Security Number:_____

_____

Print Name

_____

Signature of Patient or Personal Representative

Date:_____

If signed by patient's personal representative, describe the legal authority of the representative to act on behalf of the patient _____.