PATIENT AUTHORIZATION FORM
RELEASE OF HEALTH INFORMATION

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I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be used or disclosed:

_____

_____

_____

_____

Person or entity requesting the information and authorized to make the requested use or disclosure:

_____

Recipient of the information:

_____

This information is being requested for the following purpose(s):

_____

_____

_____

_____

This authorization shall remain in effect from the date signed below until _____ (expiration date or event).

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name:_____Signature:_____

Relationship to Patient:_____Date:_____
(If signed by a personal representative of the Patient)