Sample Authorization to Use or Disclose Health Information

Patient Name:_____

Date of Birth:_____

1. I authorize the disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

3. The type of information to be disclosed is as follows (check the appropriate boxes and include other information where indicated)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization records
- ☐ most recent history
- ☐ most recent discharge summary
- ☐ lab results (please describe the dates or types of lab tests you would like disclosed):
- ☐ x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ☐ consultation reports from (please supply doctors' names):
- ☐ entire record
- ☐ other (please describe):

- ☐ Information related to treatment for any sexually transmitted disease, including HIV or AIDs *
- ☐ Information related to treatment for mental health-related illnesses*
- ☐ Information related to treatment for substance abuse*

**Must be checked for that specific information to be released.*

4. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name:

Address:

5. This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ my personal records
- ☐ sharing with other health care providers as needed
- ☐ other (please describe):

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire in (insert date or event):

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient _____

_____ _____

Signature of witness Date

Distribution of copies: Original to provider; copy to patient; copy to accompany use or disclosure