

## 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