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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Individual's Name	Birthdate
Individual's Address	Individual's Telephone Number

I authorize _____ to disclose the following medical
(Name of Practitioner that maintains the requested records)

records or other protected health information regarding the individual identified above: _____

_____

If requesting use or disclosure of psychotherapy notes, please check the following box: ☐

The information to be disclosed or used is limited to the following date(s) of treatment: _____

The requested information may be disclosed to and used by the following person or entity:

Name: _____

Address: _____

Telephone Number: _____

This request is being made for the following purpose(s): _____

_____

(The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)

I understand the following:

1. The information being requested to be used or disclosed may include information relating to Human Immunodeficiency Virus (HIV), sexually transmitted diseases, other communicable diseases, mental health conditions, or drug or alcohol abuse.

2. Practitioner may not condition treatment on whether I sign this Authorization.

3. I may change my mind and revoke this Authorization at any time; however my revocation will only apply to future uses and disclosures of my information and will not apply to any uses or disclosures that Practitioner made prior to receiving my written revocation. To revoke the Authorization, I need to send a written request to: **[Name and Address of Practitioner's Privacy Officer]**

4. Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and no longer subject to HIPAA.

5. I have the right to receive a copy of this Authorization.

Signature of Individual	Date
Name of Personal Representative	Description of Personal Representative's Authority to Act for Individual
Signature of Personal Representative	Date

This authorization expires on (specify either a date or event): _____