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INDIVIDUAL PATIENT'S AUTHORIZATION

☐ Check if this authorization if for psychotherapy notes. If this authorization if for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they must further disclose the protected health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except

(1) If my treatment is related to research, or (2) Health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Printed Patient Name **Date of Birth** **Social Security Number**

PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Specifically describe the information you are authorizing to be used and/or disclosed (Examples being dates of service or level of data to be released). _____

RESTRICTIONS

I request the following restrictions to the use or disclosure of my health information_____

Purpose of Use and/or Disclosure of Protected Health Information

_____This authorization is at the request of the individual (Patient must initial).

_____Describe the purpose(s) of the request_____

☐***Disclose*** the above health information to: _____

☐***Obtain*** the above health information from: _____

☐***Expiration*** This authorization will expire: _____/_____/_____

☐***Revocation*** This authorization was revoked: _____/_____/_____

INDIVIDUAL PATIENT'S SIGNATURE

I understand that I have the right:

- To inspect or request a copy of information that is used or disclosed under this authorization. I understand and agree that I am financially responsible for the fees associated with my request.
- To refuse to sign this authorization. • To a copy of this form.
- To complete a Restriction Request if 14 -18 years of age who do not wish parents or guardians copies of their health information.

I have had the chance to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you my use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature_____ **Date** _____

Patient or patient's representative month day year

Office Use Only

Verified ID of patient or personal Rep. _____ Employee Initial _____ Date _____