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I HEREBY AUTHORIZE THE USE OF DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE PROTECTED HEALTH INFORMATION ("PHI") AS DESCRIBED BELOW. THIS AUTHORIZATION INCLUDES ANY INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT, COMMUNICATIONS WITH PSYCHIATRISTS OR PSYCHOLOGISTS OR RECORDS PERTAINING TO SEXUALLY TRANSMITTED DISEASES, IF THEY ARE A PART OF MY MEDICAL RECORD. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. ONCE THIS INFORMATION HAS BEEN DISCLOSED, IT MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS.

PATIENT NAME:_____
PATIENT DOB:_____

PATIENT/ORGANIZATIONS PROVIDING THE INFORMATION _____
_____
_____

PERSONS/ORGANIZATIONS RECEIVING THE INFORMATION: _____
_____
_____

DISCLOSE THE FOLLOWING PHI FOR TREATMENT DATES: _____TO_____

_____FACE SHEET
_____HISTORY AND PHYSICAL
_____EMERGENCY ROOM RECORDS
_____LAB REPORTS
_____CLINIC NOTES
_____CONSULTATIONS REPORTS (PLEASE SPECIFY PHYSICIAN NAME)
_____DIAGNOSTIC PROCEDURE REPORTS
_____X-RAY REPORTS
_____OTHER: PLEASE DESCRIBE_____

PURPOSE OF USE AND DISCLOSURE

THIS INFORMATION FOR WHICH I'M AUTHORIZING DISCLOSURE WILL BE USED FOR THE FOLLOWING PURPOSE:

_____MEDICAL CARE _____LEGAL _____INSURANCE
_____PERSONNAL _____SHARING WITH OTHER HEALTH CARE PROVIDERS AS NEEDED.

THIS AUTHORIZATION SHALL EXPIRE ON THIS DATE_____IF I FAIL TO SPECIFY A DATE, THIS AUTHORIZATION WILL EXPIRE (6) SIX MONTHS FROM THE DATE WHICH IT IS SIGNED. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND I MUST DO THIS IN WRITING AND PRESENT THE WRITTEN REVOCATION TO _____. I UNDERSTAND THAT THIS REVOKATION WILL NOT APPLY TO ANY INFORMATION WHICH HAS ALREADY BEEN SUPPLIED BY THIS AUTHORIZATION. THE INFORMATION USED OR DISCLOSED PURSUANT TO THE AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED.

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE PRINTED NAME OF PATIENT

_____ _____
RELATIONSHIP TO THE PATIENT DATE

WITNESS: _____ DATE: _____

IF YOU HAVE MEDICAL ASSISTANCE YOU WILL NEED TO CONTACT THEM AT THE NUMBER ON THE BACK OF YOUR CARD AND CHANGE YOUR PCP TO YOUR NEW DOCTOR PRIOR TO YOUR FIRST APPOINTMENT!