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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

PRINTED NAME OF PATIENT: \_\_\_\_\_

PATIENT SSN: \_\_\_\_\_ PATIENT DOB: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

I HEREBY AUTHORIZE \_\_\_\_\_ (COVERED ENTITY)  
TO USE OR DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION (PHI) FROM THE MEDICAL  
RECORDS OF THE PATIENT LISTED ABOVE TO:

REQUESTOR NAME: \_\_\_\_\_

REQUESTOR ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DISCLOSE THE FOLLOWING PHI FOR TREATMENT DATES \_\_\_\_\_ TO \_\_\_\_\_

\_\_\_\_ ANY AND ALL MEDICAL RECORDS      \_\_\_\_ OFFICE NOTES  
\_\_\_\_ OPERATIVE REPORTS                      \_\_\_\_ MRI REPORTS  
\_\_\_\_ X-RAYS    \_\_\_\_ OTHER \_\_\_\_\_

THE ABOVE INFORMATION IS DISCLOSED FOR THE FOLLOWING PURPOSES:

\_\_\_\_ MEDICAL CARE    \_\_\_\_ LEGAL    \_\_\_\_ INSURANCE    \_\_\_\_ PERSONAL    \_\_\_\_ OTHER

IF OTHER, PLEASE LIST THE REASON: \_\_\_\_\_

THIS AUTHORIZATION SHALL EXPIRE UPON THIS EXPIRATION DATE: \_\_\_\_\_

IF I FAIL TO SPECIFY AN EXPIRATION DATE OR EVENT, THIS AUTHORIZATION WILL EXPIRE 6 (SIX) MONTHS  
FROM THE DATE ON WHICH IT WAS SIGNED.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT

I MUST DO SO IN WRITING AND PRESENT THE WRITTEN REVOCATION TO THE CUSTODIAN OF MEDICAL  
RECORDS. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY  
BEEN RELEASED PER THIS AUTHORIZATION. ONCE WE DISCLOSE THIS INFORMATION PER YOUR INSTRUCTIONS  
THE INFORMATION IS SUBJECT TO RE-DISCLOSURE AND MAY NO LONGER BE PROTECTED BY THE HIPAA OF  
1996.

\_\_\_\_ DATE                                      \_\_\_\_ SIGNATURE OF PATIENT OR REPRESENTATIVE                                      \_\_\_\_ RELATIONSHIP TO PATIENT

FOR FACILITY USE: DATE RECEIVED \_\_\_\_\_ DATE INFORMATION RELEASED \_\_\_\_\_