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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:			Date of Birth:
Last	First	Middle	
			I voluntarily authorize and direct the health care provide
	<u>disclose my h</u>	ealth information durir	ng the term of this authorization to the recipient that I have
identified below.			
Name of Provider	·:		
Address of Provid	ler:		
Tel #:			
Fax#:			
Recipient and A	daress for De	elivery of Records:	
Purpose: I und	erstand that tl	he specific purpose of	this authorization is:
Information to be the following med		This authorization pe	rmits the above named health care provider to disclose
to any medical h limitation, x-rays,	nistory, menta HIV/AIDS sta	al or physical conditionatus, genetic testing,	has in his or her possession, including information relating on and any treatment received by me, including withou psychotherapy notes, billing information, correspondence the above-named health care provider may hold.
All of my h	nealthcare info	ormation described ab	ove except for the following:
Only the treatment or othe	_		health information: (Insert dates of treatment, types o
			~·

Term: This Authorization will remain in effect for 3 months from the date of this signed authorization.

<u>Redisclosure:</u> I understand the that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

<u>Refusal to sign/right to revoke:</u> I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires, or I provide written notice of revocation to my healthcare provider at my health care providers regular office address. The revocation will be effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my healthcare provider for any answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this Authorization from my healthcare provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Signature	Date	Signature of Witness	
Name:(Please Print)			
If individual is unable to sign this Author	rization, please complete	the information below.	
Signature of Personal Representative	Legal Relationship	Signature of Witness	S
	Name:		
Date	(Please Print	t)	
We charge a \$40.00 clerical fee plu payment and signed Request for applies for a RUSH request (RUSH	Release of Medical R	ecords form. An	
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	Signature:		Eyn Date: