AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Your privacy is very important. However, there may be a time when I need to speak with another person or agency to provide the best possible service to you. This form authorizes me to release and/or receive protected information from your health record to the person you designate.

Patient's Name: _____ Date of Birth: _____

I authorize my clinician, _____, and his/her administrative staff to release and/or receive the following information: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible)

_____

_____

_____

This information should be released only to the following person(s) or agencies:

_____

_____

_____

I understand that:

- Unless otherwise specified, this authorization shall remain in effect for up to 90 days after the date of signing.
- I have the right to revoke this authorization at any time by sending such written notice to my clinician. However, my request will not apply to actions my clinician has already taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.
- My clinician generally may not condition services upon my signing this authorization unless the services are provided to me for the purposes of creating health information for a third party.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. My clinician cannot guarantee that the recipient will protect my information once it leaves his/her office.

Signed: _____ Date: _____

If this authorization is signed by a personal representative of the patient, please describe a description of such representative's authority to act for the patient.