AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: ______________________________ Date of birth: ______________

Previous name: ______________________________ Social Security No. ___________

I. My Authorization

You may use or disclose:

All my health information maintained by the above named health care provider or entity, including informatio relating to any aspect of my care and treatment.

Include or Exclude: My health information related to drug/alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

This authorization is being provided for the purposes of:

This authorization ends: 1 year from date of authorization

II. My Rights

This authorization is voluntary. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I am entitled to a copy of thi authorization.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________________ ______________ ______________

Patient or legally authorized individual signature   Date   Time

______________________________ ______________________________

Printed Name if signed on behalf of the patient   Relationship (parent, legal guardian, personal representative, etc.)