

PATIENT AUTHORIZATION

FOR

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(General)

1. **Authorization.** By signing this Authorization, I authorize the Department's Privacy Officer to use and/or disclose to the person or entity named below the protected health information described below ("PHI").

2. **Purpose.** This Authorization is granted for the following purpose(s): _____

If I have initiated this Authorization and do not wish to indicate the purpose for the use or disclosure of PHI, I may simply state that this Authorization is "at the request of the undersigned." [To choose that option, check here _____.]

3. **Expiration Date/Event.** This Authorization is valid until ___/___/___ or until the following event: _____.

4. **Limitations.** In addition to the above, the following is/are other criteria or limitations that I make regarding this Authorization:

_____.

5. **Voluntary Act.** I expressly acknowledge that this Authorization is voluntary.

6. **Pre-conditions.** I understand that the Department may not condition the provision to me of treatment on my signing this Authorization.

7. **Revocation.** I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to the Department's Privacy Officer. However, any revocation shall not apply to the extent that the Department has taken action in reliance on this Authorization.

8. **Re-disclosure.** I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Department or the HIPAA Privacy Rules.

9. **Copy of Authorization.** If the Department has requested this Authorization from me, I understand that the Department will provide me with a copy of this Authorization once signed by me.

Name of Individual (Printed)

Signature of Individual

Signature of Personal Representative

Relationship (e.g., Guardian, Parent if a minor)

Date Signed ____ / ____ / ____

DESCRIPTION OF PHI (also indicate PHI time reference – for example, PHI dated _____
to _____): _____

DISCLOSE PHI TO: _____
