

## Authorization for Disclosure of Protected Health Information

I, \_\_\_\_\_, authorize the disclosure of my protected health information<sup>1</sup> as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws,<sup>2</sup> subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Name(s) \_\_\_\_\_

Organization(s) \_\_\_\_\_

Address \_\_\_\_\_

2. I authorize the following person(s) and/or organization(s) to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.

Name(s) \_\_\_\_\_

Organization(s) \_\_\_\_\_

Address \_\_\_\_\_

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):
4. Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space):
5. I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to \_\_\_\_\_ (name of person or organization and address) saying that I am revoking my authorization to disclose health records, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. This authorization expires on \_\_\_\_\_, or in the event  
(date)  
that \_\_\_\_\_, whichever occurs first.  
(event)

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

\_\_\_\_\_  
Relationship or Authority of Personal Representative  
(if applicable)

\_\_\_\_\_  
<sup>1</sup>Protected health information (“PHI”) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

<sup>2</sup>These laws apply to health plans, health care providers, and health care clearinghouses.