Patient Name: _____Account #: _____
DOB: Age: Gender:

Individual Patient's Authorization Form

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

You give your authorization to use or disclose your protected health information as described in Section 2 below. You give this authorization voluntarily.

1. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed.

_____
_____
_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you **are authorizing** to use and/or to disclose the protected health information described above.

_____
_____
_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you **are authorizing** to receive and use your protected health information.

_____
_____
_____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

_____
_____
_____

Patient Name: _____Account #: _____
DOB: Age: Gender:

Name the people and/or organizations (or the kinds of people and/or organizations) that you **are NOT authorizing** to receive and use your protected health information.

_____
_____
_____

2. ENDING THIS AUTHORIZATION

Select by checking one of the following two choices:
___This authorization will end on the following date:_____

___This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below.

_____
_____
_____

3. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

You understand that you may revoke this authorization at any time by giving written notice to the Privacy Offices at our office. However, you understand that you may not revoke this authorization for any actions taken before receipt of your written notice to revoke this authorization. In addition, you understand that if you are giving this authorization as a condition of obtaining insurance coverage and you revoke this authorization, the insurance company has a right to contest your claims under the insurance policy.

4. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

You understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on

your signing this authorization. However, you understand that signing an authorization that permits the use and/or disclosure of your protected health information for research purposes may be a condition of your treatment if you are undergoing research-related treatment. Under some circumstances, a health plan may condition your enrollment in a health plan or your eligibility for benefits on your providing an authorization permitting the health plan to make enrollment and eligibility determinations.

5. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form. I also understand that once information is disclosed to a third party, that party may in turn disclose it to someone else also who is not covered by laws protecting confidentiality.

Signature:_____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's
Name/Relationship: _____
Print Name/Relationship

_____
Signature

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT