



Authorization to Use or Disclose Protected Health Information

Patient Name : _____

Social Security # : _____ Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information described below

The following individual(s) or organization(s) are authorized to make this disclosure:

The information identified below may be disclosed to or used by the following
Individual or Organization

Name _____

Address _____

The Type of information requested to be used or disclosed is as follows:

- _____ Problem List
- _____ Medication List
- _____ List of Allergies
- _____ Immunization Records
- _____ Most Recent History / Diagnosis
- _____ Discharge Summary for Admission on _____
- _____ Lab Results - Please list specific tests and dates below
- _____ X-Ray and Imaging Reports - Please specify below
- _____ Consultation Report - Please specify below
- _____ Operative Report: Procedure _____ Date _____
- _____ Progress Notes Date(s) _____
- _____ Psychotherapy Notes
- _____ **ENTIRE RECORD**
- _____ Other _____

Specially Protected Information - Please check all that apply

- I understand that the information to be disclosed may include information about treatment for drug, alcohol, or substance abuse.
- I understand that the information to be disclosed may include information relating to AIDS or HIV.
- I understand that the information to be disclosed may include information about voluntary inpatient or involuntary outpatient mental health care.

This Information for which I am requesting disclosure will be used for the following purpose:

- My Personal Use
- Life Insurance Coverage Evaluation
- Disability Benefits Eligibility
- Attorney Request - Name _____
- Insurance - Psychiatry
- Other - _____

I understand that I have the following rights:

- > **Right Not to Sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Family Healthcare Partners, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- > **Right To Revoke.** You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at Family Healthcare Partners.
- > **Re-Disclosure.** I understand that once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization.

Signature of Patient (or Personal Representative)

Date

Expiration Date _____

If Personal Representative - Name and Relationship to Patient