_____ (Full Name of Practice)

AUTHORIZATION FOR PHI USE/DISCLOSURE BY PRACTICE FORM

Patient Name: _____ Date of Birth: _____ Health Record No. _____
Patient Address: _____

By signing below, I hereby authorize the use or disclosure of the above-named Patient's individually identifiable and protected health information ("PHI") by the above-named Practice for the specific purpose(s) stated below [which do not relate to the day-to-day functions performed by the Practice with regard to my Treatment, Payment and certain Health Care Operations and are not otherwise required or permitted by law]:

FULL NAME OF PRACTICE

Person/Entity to Receive PHI (Complete Only If Practice Is To Disclose PHI):

Person/Entity_____
Address _____
City, State Zip _____

INSTRUCTIONS: PATIENT TO "X", DATE AND INITIAL ALL APPLICABLE SECTIONS BEFORE SIGNING.

(1) _____ The type and amount of my PHI to be used or disclosed by the Practice is as follows, subject to any content or time limits listed below:

_____ Entire Patient Record (or specify below)
_____ Medication List _____ Allergy List _____ Immunization Record
_____ Lab Result(s) _____ Treating/Consulting Physician Reports
_____ Most Recent H&P _____ Most Recent Discharge Summary
_____ Lab Result(s) _____ X-ray and Imaging Report
_____ Other

State the particular purpose(s) and any Patient-imposed limitation(s) or expiration date, event or condition(s) or "None," here:

_____
_____

(2) If my PHI contains information regarding a communicable disease, acquired immunodeficiency syndrome (AIDS) or human imunodeficiency virus (HIV), mental health psychotherapy services, treatment for alcohol and drug abuse or genetic testing information ("Special PHI"), then I hereby authorize the following Special PHI to be disclosed to the above-named Person/Entity for the following purpose(s) [Patient to check, date, initial and state purpose only if applicable]:

Purpose(s) of Disclosure to Person/Entity

_____ Communicable Disease _____

_____ AIDS or HIV Status _____

_____ Mental Health Services _____

_____ Drug and Alcohol Treatment _____

_____ Genetic Testing Information _____

(3) I understand that if I do not specify an expiration date, event or condition in (1) above, this Authorization will expire in sixty (60) days (or in the case of PHI concerning mental health services, one hundred and eighty (180) days) from the date this Authorization is signed by the above-listed Patient.

(4) I understand that the PHI used or disclosed may be subject to redisclosure by the Person/Entity receiving it and no longer protected.

(5) I understand that my signature on this Authorization is voluntary and my refusal to sign will not affect my ability to receive treatment from the Practice. I understand that I have a right to revoke this Authorization at any time, in a letter addressed to the Practice at the above-listed Practice address, but the revocation will not apply (1) to PHI that has already been released in reliance on this Authorization, or (2) to PHI created by the Practice expressly for disclosure to the above-listed Person/Entity.

(6) I understand that if I have any questions regarding the use or disclosure of my PHI, I can contact _____ at any time

_____

Patient or Personal Representative* Signature Date

(*) If signed by Personal Representative, state relationship to Patient: _____