*A Professional Association*

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# AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize

NAME OF DISCLOSING PARTY ______________________________

ADDRESS ______________________________

CITY ______________ STATE ______________ ZIP ______________

to disclose to

NAME OF RECEIVING PARTY ______________ PHONE # ______________ EXT. ______

ADDRESS ______________________________

CITY ______________ STATE ______________ ZIP ______________

records and information pertaining to

NAME OF PATIENT (LIST OTHER NAMES USED) ______________ SOCIAL SECURITY # ______________ DATE OF BIRTH ______________

ADDRESS ______________________________ TELEPHONE NUMBER ______________

**DURATION:** This authorization shall become effective immediately and shall remain in effect until ______________ (DATE) or for one year from the date of signature.

**REVOCATION:** This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

**REDISCLOSURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**SPECIFY:** Check the box and initial to specify which type of information is to be disclosed.

**RECORDS:**

**MEDICAL INFORMATION** ________ (INITIAL)

☐ **RESULTS OF AN HIV BLOOD TEST**

______________________ SIGNATURE ______________ DATE

**OTHER HEALTH INFORMATION** ________ (specify below)

Specify the records to be disclosed: ______________________________

______________________________

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______________________________

The requester may use the health information authorized on this form for the following purposes only: ______________

______________________________

______________________________

______________________________

Date: ______________________ Signature: ______________________