AUTHORIZATION OF USE AND DISCLOSURE OF PHI

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Purpose of the Disclosure:

Persons Authorized to Use or Disclose the Above Information:

_____

_____
(Name of person or organization)

Persons to Whom Information May Be Disclosed:

_____

_____
(Name of person or organization)

Expiration Date of Authorization
This authorization is effective through (check one) ❑ _____/_____/_____ or ❑ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

_____
Name of Patient (Print)

_____
Signature of Patient **Date**

_____
Signature of Patient Representative and Relationship (if applicable)

_____
Physician Signature **Date**