

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below:

Description of the specific information to be used or disclosed:

Person or entity requesting the information and authorized to make the requested use or disclosure:

Recipient of the information:

The information is being requested for the following purpose(s):

The authorization shall remain in effect from the date signed below until:

_____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above to attention: **Privacy Officer**.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

_____ If this line is checked, I understand that I authorize you to bill and receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ **Signature:** _____

Relationship to Patient

(If signed by personal representative of Patient): _____

Date: _____