Authorization for Use and\or Disclosure of Patient Health Information

Leave Blank, for office use only

I hereby authorize:

____

To Disclose to:

____

or to their representative; **Professional Services.**

Records and information pertaining to:

____
(Patient Name)

Duration: This authorization shall become effective immediately and shall remain in effect until ______________________________
or three years from the date of signature.

I acknowledge my right to receive a copy of this signed authorization. Copies of this signed authorization will be considered as valid as the Original.

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524

Re-disclosure: 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.

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 Requestor or others have acted in reliance upon this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Records to be Released:

☒ Medical Information

☐ Psychiatric Information

____
(Signature) (Date)

☐ Drug \ Alcohol Information

____
(Signature) (Date)

☒ Other Information (Specified below)

Specifying the other records to be disclosed: Any and all records, including but not limited to: diagnosis, testing, treatment, in patient or out patient records, any correspondence, computerized records, billing records or any other documents under your custody and control.

Purpose: The requestor may use the information authorized on this form for the following purpose only: To investigate the patients claim of injury.

A copy of this Authorization is as valid as the original.

The signer / patient has a right to a copy of this Authorization.

Date: ______________ **Signature:** ______________________________