



AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient's Name :

SSN :

Date of Birth :

Phone # :

Address :

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. PERSONS/ORGANIZATIONS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION : (place of treatment)

SRHS Clinics Specify location of Clinic:

2. PERSON/ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION : (who will be getting these records)

Patient or Patient's Legal Guardian/Representative

Physician _____ Office#: (_____) _____ FAX#: (_____) _____

OTHER – person authorized to pick-up your records: _____ relation: _____

3. SPECIFIC DESCRIPTION OF INFORMATION THAT MAY BE USED OR DISCLOSED : (dates of service)

Date (s) of Service :

Needed from the records :

ABSTRACT Dictation Mental Health HIV

COMPLETE Tests Drug\Alcohol OTHER _____

4. THE INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE : (reason for wanting records)

Continuation of Care Insurance Purposes OTHER _____

Personal Record Releasing to an Attorney

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

6. I understand that I may inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the person/organization providing this the information in writing, except to the extent that: (A) action has been taken in reliance on this authorization; or (B) authorization is obtained as a condition for obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under policy.

8. This authorization will expire in 6 months unless otherwise stated. _____

Signature of patient or patient's representative

_____/_____/_____
Date

Printed name of patient or patient's representative
OR Authority to act for the patient

Relationship to Patient

SRHS Clinic Employees: A copy of this signed form will be provided to the patient

