

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

*This form may not be used to authorize release of HIV-related information or psychotherapy notes that are recorded and kept separately by a mental health professional documenting the contents of a conversation during a counseling session.*

Individual's Name: \_\_\_\_\_

Health Plan ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize \_\_\_\_\_  
to disclose my protected health information as follows:

## INFORMATION TO BE DISCLOSED

\_\_\_\_\_  
\_\_\_\_\_

Include genetic information.

## RECIPIENT OF INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

## REASON FOR DISCLOSURE

At my request.

- or -

For the following purposes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TERM OF AUTHORIZATION

Authorization will remain in effect until the \_\_\_\_\_  
day of \_\_\_\_\_, 200\_\_.

- or -

Authorization will remain in effect until I revoke it in  
writing, but for no longer than 24 months from the  
initial date of authorization.

## CONDITIONS OF AUTHORIZATION

I understand that:

- ✓ I may refuse to sign this authorization.
- ✓ I will receive a signed copy of the authorization.
- ✓ The information released to a third party pursuant to the authorization may no longer be covered by state and federal privacy laws.
- ✓ I have the right to revoke the authorization at any time, and that the revocation must be in writing.
- ✓ The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not affect any action taken in reliance on the authorization prior to receipt of my written notice of revocation.
- ✓ The authorization will be maintained for a period of six (6) years or as prescribed by law.
- ✓ A health plan will not condition my enrollment or eligibility for health insurance benefits on my provision of the authorization, unless it requested the authorization before my enrollment solely for eligibility or enrollment determinations relating to me.
- ✓ A health plan may not condition payment of a claim for specified health insurance benefits on my provision of the authorization.

I have read and understood the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the use and disclosure of my health information in the manner described above.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Date

If individual is a minor or otherwise unable to sign this authorization, the following is required:

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

## DESCRIPTION OF AUTHORITY

Parent  Legal Guardian\*  Power of Attorney\*