SAMPLE AUTHORIZATION FORM

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying the medical practice in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the medical practice in reliance on this authorization.

I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

(1) Description of the information to be used or disclosed ______________________________
________________________________________________________________________________
________________________________________________________________________________

(2) The person or persons, or class of persons, authorized to make the requested use or disclosure
________________________________________________________________________________
________________________________________________________________________________

(3) The person or persons, or class of persons, to whom the medical practice may is authorized to make
the use or disclosure _____________________________________________________
________________________________________________________________________________
________________________________________________________________________________

(4) A description of each purpose of the requested use or disclosure ______________________
________________________________________________________________________________
________________________________________________________________________________

(5) This authorization expires on ___________ (Date)
(or in the alternative)

This authorization expires upon the occurrence of the following event.

________________________________________________________________________________
________________________________________________________________________________

(6) ___________________ ___________________ (Signature of Patient) (Date)

(7) ___________________ ___________________ (Signature of Patient’s Personal
Representative) (Date)

If signed by the patient’s personal representative, the personal representative’s authority to act for the patient ______________________________