Authorization For Use Or Disclosure Of Health Information

1. Client's Name _____
(First, Middle, Last)

2. Date of Birth: ___ /___ /____ 3. Date authorization initiated: ___ /___ /____

4. Authorization initiated by:_____
Name (client, provider, or other)

5. Information to be released: _____

6. Purpose of Disclosure: The reason I am authorizing release is:_____

_____

7. Person(s) Authorized to Make the Disclosure:_____

8. Person(s) Authorized to Receive the Disclosure:_____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____
Signature of Client

_____
Signature of Personal Representative

Relationship to Patient if Personal Representative: _____

Date of signature: _____/_____/_____