# Authorization For Use Or Disclosure of Protected Health Information

Note: All Sections Must Be Filled Out Completely to be Accepted

1. I, _____, voluntarily authorize the disclosure of my health record.

   The Information is to be released by:
   Name of Facility:_____
   Address: _____
   CIty/State/Zip Code: _____
   Phone & Fax Number: _____

   The information to be provided to:
   Name of Facility/Person/Organization: _____
   Address:_____
   City/State/Zip Code:_____
   Phone & Fax Number: _____

2. The purpose of need for this disclosure is: Circle One
   Medical Care
   Attorney
   School
   Transfer of Care
   Personal Use
   Disability
   Other: _____

3. The Information to be disclosed from my health record: Circle Appropriate One
   Only Information Related to: _____
   Only period of events from: _____ to:_____
   Other (Specify):_____
   Entire Record
   If you would like any of the following sensitive information disclosed, circle the appropriate one below
   Alcohol/Drug Use Treatment
   HIV/AIDS Related Treatment
   Sexually Transmitted Disease History
   Mental Health Diagnoses and Treatment

4. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition to obtaining medical insurance coverage or policy of insurance, other lay people may provide the insurer with the right to consent a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration event is stated.

Date of termination: _____

I understand that OPHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) research related or 2) for the sole purpose of creating protected health information for disclosure to a third party. I understand that information disclosed by this authorization, except Drug and Alcohol abuse as defined in 42 CFR Part 2, may be subject to re disclosure by the recipient and my no longer be protected by Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164) and the Privacy Act of 1974 (5 USC 552a).

_____
Signature of Patient/Date

_____
Printed Name/DOB

_____
Address:

_____
City/State/Zip Code: