_____Doctor Name
_____Office Address

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Note: Do Not Use This Form If Records To Be Released Relate to HIV Test Results)

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information ("PHI") about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent us from acting on this Authorization.

Name of Patient:_____ Date of Birth:_____

Other Names: _____ Account #:_____

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below*: (State name of physician or specific identification of person or class of persons)*_____

_____

_____

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required).*

☐ _____ (Initial) All my health information pertaining to any medical history, physical condition and treatment received. Except *(optional)*:_____
Or, only the following records or types of health information and/or only on the specified date(s):
Date(s) of Treatment: _____ Type of Treatment: _____

☐ _____ (Initial) Other _____

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *(State name and title if applicable.)* **Name:** **Title** (if applicable)

Address: _____City, State, Zip _____

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)(No authorization needed for research release)*

☐ Requested by patient or personal representative. ☐ Other: _____

Physician or practice will be remunerated for this information. Yes☐ No☐

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, providing that my revocation is in writing and conforms to requirements described in the ProHealth Partners/Argus Notice of Privacy Practices.

6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.

7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 avove is not a healthcare provider, a health plan or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

8. CALIFORNIA RESTRICTIONS. I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.

10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified.
End date_____ Or Event _____

11. COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization_____(Initials)

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name of Personal Representative (if applicable) Relationship of Personal Rep. to Patient

_____ _____
Address Phone number

_____ ____ ____ _____
Type of pt./rep. ID presented. Attach copy (optional) Verified Yes No Initials who verified

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE