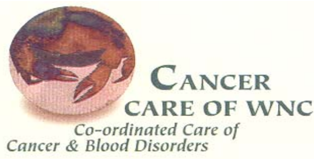

Copies of this signed authorization will be considered as valid as the original

Name: ______________________________

MR #: ______________________________

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize ______________________________

NAME OF DISCLOSING PARTY

____

ADDRESS

____

CITY STATE ZIP

To Disclose to ______________________________

NAME OF RECEIVING PARTY

____

ADDRESS

____

CITY STATE ZIP

Records and information pertaining to:

NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORDS NUMBER DATE OF BIRTH

ADDRESS TELEPHONE NUMBER

DURATION: This Authorization shall become effective immediately and shall remain in effect until ____________________ (DATE), or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the Requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify the records to be disclosed: ______________________________

____

____

The Requester may use the health information authorized on this form for the following purposes only:

____

____

______________________________ ______________________

Patient Signature **Date**

______________________________ ______________________

Parent/Guardian Signature **Date**

______________________________ ______________________

Witness Signature **Date**