AUTHORIZATION

SECTION A: Individual authorizing use and/or disclosure.

Name: _____

Address: _____

Telephone: _____ Member Identification Number: _____

SECTION B: The use and/or disclosure being authorized.

PHI to Be Used and/or Disclosed: **{Specifically describe the PHI to be used and/or disclosed}**

_____

_____

☐ Check if this authorization is for psychotherapy notes

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information (PHI).

Entities or persons Authorized to Use or Disclose: **{Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose PHI described above}**

_____ _____

_____ _____

Entities or Persons Authorized to Receive: **{Name or specifically describe the person and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above}**

_____ _____

_____ _____

Purpose of this Authorization:

☐ At request of individual

☐ For the following purposes:

_____

_____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C: Expiration and revocation.

Expiration: This authorization will expire (Complete one):

- ☐ On _____/_____/_____
- ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: _____

Telephone: _____ Fax: _____

Address: _____

INDIVIDUAL'S SIGNATURE.

I, _____ have had full opportunity to read and consider the Contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name: _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative, i.e. **with Legal Authority** to act on behalf of the individual, complete the following:

Personal Representative's Name: _____

Signature: _____ Date: _____

Relationship to individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.