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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To: _____ [Description of providers]

I, _____ [patient name], hereby authorize the release of protected health information about me. The specific information and purpose I am authorizing this release are the following:

_____

The recipient(s) of this information is/are to be [description of recipients]:

_____

The information is to be transmitted by:

_____

I am aware that my records may contain health care information relating to testing, diagnosis, or treatment for HIV/AIDS or for any other STI, for chemical dependence, and/or mental health. If not excluded by initialing below, I specifically authorize the Provider to disclose any and all such information.

My initials constitute my intention to exclude from this authorization health care information relating to testing, diagnosis, or treatment for the corresponding condition, illness, or disease:

_____ HIV/AIDS _____ Chemical dependency _____ Mental health

I understand that I may revoke this authorization in writing at any time; that the Provider will make a Revocation of Authorization form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand that the Department of Social and Health Services' certified drug and alcohol programs will honor verbal revocations upon authenticating my identity.

I understand that re-disclosure of my health information by Recipient, if unauthorized, is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that I do not have to sign this authorization in order to obtain treatment benefits from the Provider, except for health care services necessary to create any assessment or report contemplated by this authorization. I understand that I am entitled to a copy of any authorization I sign.

The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization will expire in 90 days or upon the following date: _____, or upon the following event: _____.

_____ _____
Signature of Patient (or Parent or Legal Guardian) Date