MEDICAL AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____[Print Name]_____ hereby authorize the **[check items that apply]:**

- ☐ use of my protected health information as described below.
- ☐ disclosure of my protected health information as described below.

Entities Authorized to Provide Information

_____[Entity]_____, _____Address_____ is authorized to *provide* the information described below to those authorized to receive such information.

Entities Authorized to Receive Information

1. _____[Entity]_____, _____Address_____
2. _____[Entity]_____, _____Address_____
3. _____[Entity]_____, _____Address_____

is/are the person(s)/organization(s) authorized to *receive* my protected health information.

Description of Information

The following is a specific description of information to be used or disclosed (including date(s), type of service):____

_____

Purpose of Use or Disclosure

The following is a specific description of the purpose of the use or disclosure of this health information:

_____

Expiration of Authorization

Unless an earlier expiration date is specified below, this authorization will expire one year from the date it is signed. Earlier expiration date (indicate date or event that relates to you or to the purpose of the use or disclosure): _____.

— YOUR RIGHTS —

This authorization is voluntary and I understand that I may revoke this authorization at any time prior to its expiration date by notifying **the entity providing information, named above, in writing at the address above**, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that the health care provider made before it received the revocation.

I may inspect and copy the protected health information described on this form if I ask for it.

I am not required to sign this authorization to receive treatment or for the payment, enrollment or eligibility for benefits, although I recognize that failure to do so may mean that my employer does not have sufficient information to make a determination about either my leave or return to work.

Your Signature or Your Representative's Signature

_____ _____

Signature Date

Printed name of your personal representative: _____

Your relationship, including authority for status as representative: _____

If we have requested that you sign this Authorization, you are entitled to a copy of it.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION