



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 \_\_\_\_\_  
(*Requesting records from*) Name of Disclosing Party

\_\_\_\_\_  
Street, City, State, Zip

To disclose to \_\_\_\_\_  
(*To be sent to*) Name of Receiving Party

\_\_\_\_\_  
Street, City, State, Zip

Records and information pertaining to:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of Patient (List Other Names Used) SSN DOB

\_\_\_\_\_  
Street, City, State, Zip (\_\_\_\_\_) Phone

\_\_\_\_\_  
Name of Parent/Guardian (If Patient is a Minor)

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_/\_\_\_\_/\_\_\_\_ or for one year from the date of signature.

**REVOICATION:** This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information to 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.

**RECLOSURE:** 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 RECORDS AND DATES:** From \_\_\_\_\_ to \_\_\_\_\_ or All Records

Special Notes: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_