Patient Privacy Authorization to Disclose Medical Data

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

1. Recipient of Medical Information

Name of Individual/Organization: _____
Address: _____
Phone: _____

2. Description of Medical Information to Be Disclosed

_____

_____

3. Purpose of Disclosure

_____

4. Expiration Date or Event

_____

5. Authorization and Signature

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

Patient Signature:

_____

Date:

_____

If signed by authorized representative, provide name & relationship:

_____

Date:

_____

Notice: Protected health information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected under privacy regulations.
Right to Refuse to Sign: Signing this authorization is voluntary. Your health care will not be affected by your refusal to sign unless the authorization is needed for specific treatment purposes.