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Authorization to Disclose Protected Health Information
Pursuant to Health Insurance Portability and Accountability ActHIPPA),

I, ____ hereby authorize
(Print your name & SSN)

____
(Provider/Facility)
____
(Address)
____
(Tel/Fax)

To use or disclose the following protected health information from my medical record as
Instructed by me:

[ ] The entire medical record

[ ] Specific parts of the medical record

This information is to be disclosed to:

____
(Provider/Facility
____
(Address)
____
(Tel/Fax)

I understand that I may revoke this authorization, at any time, by writing to the Privacy Officer, at which time it will go into effect. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or state law. Unless otherwise revoked, this authorization will expire on 1 year. The facility, its Employees, officers, and physicians are hereby released from any legal responsibility or liability for dis-Closures of the above information to the extent indicated and authorized herein.

I fully understand and accept the terms of this information.

____ ________________________
Patient/Legal Representative Signature Date