



**AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable protected health information (“PHI”) as described below. This Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

**Patient Name:** \_\_\_\_\_  
**Patient SSN:** \_\_\_\_\_  
**Patient’s Phone #:** \_\_\_\_\_

**Medical Record #:** \_\_\_\_\_  
**Patient DOB:** \_\_\_\_\_  
**Patient’s Address:** \_\_\_\_\_  
**City, Stat, Zip:** \_\_\_\_\_

**Persons/ Organizations providing medical records:**

**Person/ Organizations receiving medical records:**

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, Stat, Zip:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_

**Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_

**Specific Description of Information:**

- \_\_\_ Face Sheet (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ History and Physical (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Emergency Room Record (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Lab Reports (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Medication List (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Clinic Notes (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Consultation Reports (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Radiology Films (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Other (Please describe & Include dates of Service): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_ Discharge Summary (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Pathology Report (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Diagnostic Procedure Report(s) (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Problem List (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ X-ray report(s) (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Operative report(s) (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ Billing Records (From \_\_\_\_\_ to \_\_\_\_\_)
- \_\_\_ All Medical Records

**Purpose of Use or Disclosure: This information for which I’m Authorizing disclosure will be used for the following purpose:**

- \_\_\_ My personal Records
- \_\_\_ Sharing with other health care providers as needed
- \_\_\_ Other: (Please Describe): \_\_\_\_\_



The patient or the patient’s representative must read and initial the following statements: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity privacy coordinator. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

\_\_\_\_\_ I understand that I may revoke this Authorization at any time by notifying Seale Harris Clinic’s Privacy Officer in writing, but if I do, it will not have any affect to the extent Seale Harris Clinic took action in reliance on the Authorization.

\_\_\_\_\_ I understand that Seale Harris Clinic may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under The following circumstances:

- Participating in research projects can be conditioned on my signing an Authorization to use and discloses PHI in the research.
- Initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.
- Furnishing healthcare services to me at the request of a third party can be conditioned on me signing an authorization for disclosure of the PHI to the third party requesting the treatment.

**This authorization will expire:** \_\_\_\_\_

**If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.**

**Signature of patient or patient’s representative:** \_\_\_\_\_

**Printed Name of Patient:** \_\_\_\_\_

**Printed Name of Patient’s Representative:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_