

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: _____
First Name Middle Name Last Name

Date of Birth: _____

I. My Authorization

The Acute Injury and Illness Center may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above named practice.
- My health information relating to the following treatment of condition:

- My health information for the following dates: _____
- Other: _____

I specifically authorize the release of information related to the conditions (check all that apply):

- Alcohol abuse treatment
- Drug abuse
- HIV status or AIDS
- Sexually Transmitted Diseases
- Mental health: psychological or psychiatric conditions

You may disclose this information to:

Name (or title) and organization: _____

Address: _____

City _____ State _____ Zip _____

Fax _____ Phone _____

Reason (s) for this authorization (check all that apply):

- At my request
- Other (specify): _____

This authorization ends: Date: _____ When the following event occurs: _____

I authorize the release of my records (check one):

- Only up to the date this authorization is signed
- Both before and after the date this authorization is signed
- Only after the date this authorization is signed

II. My Rights

I understand this authorization may be revoked in writing at any time except to the extent already acted upon by the Acute Injury and Illness Center. To revoke this authorization I must send a request in writing to the Acute Injury and Illness Center. This authorization expires within one (1) year of the date signed if I have not provided an expiration date or event. I understand that treatment, payment, or enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I understand that my information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer have privacy protection. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that I may refuse to sign this authorization.

Signature of Patient or Legal Authorized Individual Date

Printed Name Relationship to patient if legal guardian

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.