

**Authorization for the Use and/or Disclosure of Protected Health Information**

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization (*check all that apply*):

**Release All Medical Records**  
**OR**

**DO NOT RELEASE ANY**  
**INFORMATION TO ANYONE**

**EXCEPT FOR THE FOLLOWING:** (Please check only if you do not want any of the information below released)

Clinical Notes

HIV Test Results

Lab / Imaging Reports

Genetic Test Results

X-ray Film(s)

Restrict to the following Dates / Conditions:

Other: (*Please Specify*) \_\_\_\_\_

2. The doctor and his/her staff have my permission to speak to the following spouse, family member, relatives or friend regarding my medical information and/or treatment:

| Name  | Relationship | Name  | Relationship |
|-------|--------------|-------|--------------|
| _____ | _____        | _____ | _____        |
| _____ | _____        | _____ | _____        |

3. I authorize the following the Doctor(s) / person (s) not listed above to receive my protected health information:

\_\_\_\_\_  
\_\_\_\_\_

4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then the information may be re-disclosed and would no longer be protected.

5. This authorization gives the doctor and his/her staff permission to leave messages regarding my appointments or health information on my answering machine / voice mail.

6. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (e.g. letter) addressed to the doctor. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

7. This authorization shall cover the period of time from my first visit to my last. I release the doctor and staff from all legal responsibility that may arise from this authorization.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the doctor, nor will it affect my eligibility for benefits.

9. My protected health information will be used or disclosed upon request for the following purposes (*check all that is applicable*)

Personal records     Continued medical care     Insurance claim     Legal Action

Other (*Specify*): \_\_\_\_\_

10. I understand that I have the right to inspect and ask for a copy of my protected health information to be used or disclosed in accordance with the requirements of the Federal Privacy Protection Regulations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name