



Authorization for Access to Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

Health care information in my medical record for date(s): _____

Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that applies):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

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

(An assignment of benefits form is used for payment purposes.)

- At my request
- Other (specify) _____

This authorization ends: (No longer than 90 days from date signed)

- In 90 days from the date signed
- On (date): _____
- When the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party such as an exam to obtain life insurance.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by those who have relied upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form - (A form is available from us)
- Write a letter to us

Once health care information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

(Patient or legally authorized individual signature)

(Date)

(Time)

(Printed name if signed on behalf of the patient)

(Relationship to patient)

MT last revised on: 4/14/2003