INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

DRUG AND/OR ALCOHOL NOTES: ___ Check here if this authorization is for drug and/or alcohol notes.

PSYCHOTHERAPY NOTES: ___ Check here if this authorization is for psychotherapy notes.

HIV NOTES: ___ Check here if this authorization is for HIV notes.

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: _____

Your Address: _____

Your Address: _____

Your Telephone Number: _____

Your E-Mail Address: _____

Your Patient Account Number: _____

Your Social Security Number: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

_____

_____

_____

3. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.