SAMPLE AUTHORIZATION FORM

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying the medical practice in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the medical practice in reliance on this authorization.

I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

(1) Description of the information to be used or disclosed ________________________________
____
____

(2) The person or persons, or class of persons, authorized to make the requested use or disclosure
____
____

(3) The person or persons, or class of persons, to whom the medical practice may is authorized to make the use or disclosure ____
____
____

(4) A description of each purpose of the requested use or disclosure ________________________
____
____

(5) This authorization expires on ____________
(Date)
(or in the alternative)

This authorization expires upon the occurrence of the following event.

____
____
____

(6) __________________________________ ____________________
(Signature of Patient) (Date)

(7) __________________________________ ____________________
(Signature of Patient's Personal Representative) (Date)

If signed by the patient's personal representative, the personal representative's authority to act for the patient ____