AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

# Revocation

Date Revoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials of Privacy Official\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize [COVERED ENTITY] to use or disclose my health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

\_\_\_\_ The entire medical record (all information)

\_\_\_\_ Minimum Data Set

\_\_\_\_ Business Office File

\_\_\_\_ Nursing documentation/Progress Notes

\_\_\_\_ Physician and Professional Consult Progress Notes

\_\_\_\_ Diagnostic reports (lab, x-ray, etc.)

\_\_\_\_ History and physical

\_\_\_\_ Medication and treatment records

\_\_\_\_ Rehabilitative and restorative therapy documentation

\_\_\_\_ Other (Describe as specifically as possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

\_\_\_\_ Initiated at the request of the patient.

\_\_\_\_ My personal records

\_\_\_\_ Sharing with other health care providers as needed

\_\_\_\_ Other (please describe):

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. **For Marketing disclosures only: *(Check if applicable)*** \_\_\_\_\_\_I understand that [COVERED ENTITY] will receive compensation related to the use or disclosure of the requested information.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to [COVERED ENTITY]. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Unless I specify differently, this authorization will expire (insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. I understand that [COVERED ENTITY] will not condition the provision of treatment or payment on the provision of this authorization.

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

Signature of Patient or Personal Representative Date

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

Print Name

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

Personal Representative’s Title (e.g., Guardian, Executor of Estate,

Health Care Power of Attorney)

 **PATIENT AUTHORIZATION TO DISCLOSE PHI:**

**A CHECKLIST OF ELEMENTS REQUIRED BY THE HIPAA PRIVACY RULE**

A covered entity may disclose information pursuant to an authorization **only if** the authorization form includes **all** of the following elements required by the Privacy Rule. **If any one element is missing, the Privacy Rule prohibits disclosure.**

**Note**: Authorizations for research purposes must include additional elements.

* A specific and meaningful description of the information to be disclosed.
* The name or other specific identification of the person (or organization or class of persons) authorized to make the requested disclosure.
* The name or other specific identification of the person (or organization or class of persons) to whom the information will be disclosed.
* The purpose(s) of the requested disclosure. (If the patient initiates the authorization, the statement “at the request of the patient” is a sufficient description of the purpose).
* Signature of the patient or personal representative and date.
* If signed by personal representative, a description of the representative’s authority to act for the patient.
* A statement informing the patient of his or her right to revoke the authorization in writing and a statement explaining (1) how to revoke the authorization, and (2) any exceptions to the right to revoke **or** a the revocation right and procedures described in the Notice of Privacy Practices.
* A statement that the covered entity cannot condition treatment, payment, or eligibility for benefits on the patient’s agreeing to sign the authorization
* A statement that information disclosed pursuant to the authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations
* A statement that the authorization will expire: (1) on a specific date, (2) after a specific amount of time (e.g., 5 years), **or** (3) upon the occurrence of some event related to the patient or the purpose of the authorization

**If the authorization is for marketing purposes and the covered entity will receive direct or indirect remuneration from a third party**, the authorization **must** include, in addition to all of the elements listed above:

* A statement that the covered entity will receive direct or indirect remuneration in connection with the use or disclosure of the patient’s information for marketing.