

AUTHORIZATION TO USE AND DISCLOSE PATIENT INFORMATION

You have the right to review the provided Notice of Patient Practices before signing this form.

Printed Name of Patient: _____ **Date of Birth:** _____
Previous name(s) _____

I authorize my protected health information to be disclosed:

FROM: _____	TO: _____
FACILITY NAME	INDIVIDUAL OR FACILITY NAME
_____	_____
Address	Address
_____	_____
City, State & Zip	City, State & Zip
_____	_____
Phone #	Phone#
_____	_____
Fax #	Fax #
_____	_____

Information to be released:

The most recent 2 years of pertinent information ___AND/OR The following specific information _____

Purpose for release of information: _____

I authorize the release of the following information (INITIAL THE FOLLOWING):

Patient must authorize specific information to be released, even if patient is a minor (see age requirements next to type of record).

Information related to diagnosis and treatment of sexually transmitted diseases (**14 yrs or older**) _____

Information related to diagnosis and treatment for any condition concerning to mental health (**13 yrs or older**) _____

Information related to diagnosis and treatment of HIV or AIDS (**14 yrs or older**) _____

Information related to diagnosis and treatment for drug and/or alcohol abuse (**13 yrs or older**) _____

I UNDERSTAND THAT INFORMATION OTHERWISE PROTECTED BY LAW AND DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE, AND MAY NO LONGER BE PROTECTED BY LAW, INCLUDING BUT NOT LIMITED TO PRIVACY REGULATIONS ISSUED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

I understand that I may revoke this Authorization at any time by giving Pioneer Family Practice notice in writing. Revocation of my authorization for use and disclose of information related to drug and alcohol abuse treatment may be provided orally. I understand that this provider cannot condition treatment on my provision of this authorization.

By signing below I agree that my protected health information may be used or disclosed as described above.

Signature of Patient or Legally Authorized Representative: _____

Authority of Legally Authorized Representative: _____

Date: _____