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**Authorization to Use or Disclose My Health Information**

Patient name: \_\_\_\_\_ Maiden name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Clinic/Doctor who is to release records if other than Dr. Coats \_\_\_\_\_

Dr/Clinic Phone #: \_\_\_\_\_

**I. My Authorization/Please complete all sections or this could delay release**

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

All my health information maintained by the above named practice. (You Must Circle include or exclude for each of the following)

**Include or Exclude:** My health information related to drug abuse

**Include or Exclude:** My health information related to alcohol abuse

**Include or Exclude:** My health information related to HIV/AIDS

**Include or Exclude:** My health information related to psychological or psychiatric conditions, including psychotherapy notes

My health information relating to the following treatment or condition: \_\_\_\_\_

My health information for the date(s): \_\_\_\_\_

Xrays only: \_\_\_\_\_

**You may disclose this health information to:**

Name (or title) and organization \_\_\_\_\_

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

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

at my request Reason: \_\_\_\_\_

other (specify) \_\_\_\_\_

**\*If you need records for an upcoming appointment, please note the date:** \_\_\_\_\_

**This authorization ends:**  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 receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based 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. The form is available from the office, or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose 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 (parent, legal guardian, personal representative, etc.) \_\_\_\_\_

**\*\*If your address/phone has changed please update:** \_\_\_\_\_