
**Authorization to Use or
Disclose Health Information.pdf**

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth: _____

_____ Previous name(s):

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

- All Health Information in my medical record;
- Health Information in my medical record relating to the following treatment or condition:

 Health Information in my medical record for the date(s):

 Other (e.g., X rays, bills), specify date(s):

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus) Psychiatric disorders/mental health
- Sexually transmitted diseases Drug and/or alcohol use

You may disclose this Health Information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____
Zip: _____

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

- at my request
- other (specify) _____

Authorization Expiration: *(This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)*

- in 90 days from the date signed on (date): _____
- when the following event occurs:

(no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the WKRFA based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the WKRFA, or
- Write a letter to the WKRFA.

Once Health Information is disclosed, 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)	