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PATIENT DISCLOSURE AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

Specific description of information to be used or disclosed:

_____ progress notes only

_____ progress notes with therapy notes

_____ other: _____

Reason for requested use or disclosure: _____

Name or the person or entity to whom this practice will give/obtain my information: _____

This authorization will expire on the following date: _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the provider, except if this practice has taken action relying on the consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosure.
- I will receive a copy of this completed and signed authorization form, upon request.

Signature: _____ Date: _____

Relationship to patient(if signed by a personal rep. of patient): _____

Witness: _____ Date: _____