Authorization for Release of Information

**I. Information About the Use or Disclosure**

I hereby authorize the use and disclosure of protected health information as described below.

Participant name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons/organizations (or class of persons/organizations) authorized to receive, use and disclose the information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Specific description of information to be used and disclosed (including relevant date(s) and conditions):

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

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Specific purpose of the disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This authorization will expire on (date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Important Information About Your Rights**

I understand that:

1. This authorization is voluntary and I may refuse to sign it.
2. I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to each entity that I previously authorized to disclose health information. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
3. I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
4. The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

**III. Signature of Resident or Resident's Representative**

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

Signature of patient/participant or patient's/participant's representative                   Date

If the form is signed by a personal representative, complete the following information:

Printed name of the participant's personal representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_