

Physician Practice

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

(Note: This form cannot be used to authorize release of HIV- related information.)

Patient Name: _____

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

Specify Information To Be Disclosed: We may use and disclose PHI in order to treat you, obtain payment for services provided to you. We may also disclose PHI to other healthcare providers and/or diagnostic centers to receive information pertaining to your healthcare assessment. Your PHI may also be disclosed under New York State regulations pertaining to workman's compensation cases. Further information regarding your PHI is available to you in the NOTICE OF PRIVACY PRACTICES locate in reception room.

Recipient: Name of the persons or class of persons to whom the Practice may disclose my health information:

Address of recipient or where my health information should be delivered:

Term: This Authorization will remain in effect from the date of this Authorization until the Practice fulfills my request.

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s) ("At request of the patient" is sufficient if the patient is initiating this Authorization):

Signature: _____

Date: _____

I understand that once the Practice discloses my health information to the recipient in accordance with the terms and conditions of this Authorization; the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or