AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: **I voluntarily consent to and authorize my health care provider _____ (insert name)**

to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: **I authorize my health care information to be released to the following recipient(s):**

Name:_____ Relationship: _____

Tel/Cell:_____

Name:_____ Relationship:_____

Tel/Cell:_____

Name:_____ Relationship:_____

Tel/Cell:_____

Purpose: **I authorize the release of my health information for the following specific purpose: _____.**

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: **I authorize the release of the following health information: (check the applicable box below)**

□ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

□ **Only the following records or types of health information:**

_____.

Term: **I understand that this Authorization will remain in effect:**

From the date of this Authorization until the _____ day of _____, 20___.

Until the Provider fulfills this request.

Until the following event occurs:_____

Redisclosure: **I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The 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.**

Refusal to sign/right to revoke: **I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at _____. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.**

Questions: **I may contact the Office of Compliance for answers to my questions about the privacy of my health information at 2810 North Loop 1604 West – Suite #102, San Antonio, TX 78248 or by telephone 210-568-7555.**

_____ _____ _____

Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian/Legal Relationship Date Witness Representative