

Model Authorization For The Use And/Or Disclosure Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

_____ (alternatively, you may wish to develop a checklist for the authorizer to circle or check off)

3. I authorize the following persons (or class of persons) to receive my protected health information:

_____ (alternatively, you may wish to develop a checklist for the authorizer to circle or check off)

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (insert explanation of how to revoke: e.g. on the form provided to me / in a letter). I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____ (insert date or an event that triggers expiration).

If the Authorization is requested by a Covered Entity for its own use, also include:

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from (insert entity's name), nor will it affect my eligibility for benefits. (OMIT #7 if the authorization applies to a provider of research-related treatment, a health plan offering enrollment or eligibility for benefits or specialized benefits, or a Covered Entity providing care solely for the purpose of creating PHI for disclosure to another person.)

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

_____ (alternatively, you may wish to develop a checklist for the authorizer to circle or check off)

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

10. I understand that (*insert entity's name*) will receive compensation for its use and/or disclosure of my protected health information. (*OMIT #10 if not applicable*).

If the Authorization is requested by a Covered Entity for disclosure to another Covered Entity for the purposes of treatment, payment or health care operations, the Authorization must, in addition to elements 1-6 include:

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from (*insert entity's name*), nor will it affect my eligibility for benefits. (*OMIT if the authorization applies to a health plan offering eligibility for specialized benefits.*)

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

(*alternatively, you may wish to develop a checklist for the authorizer to circle or check off*)

I certified that I have received a copy of the authorization.

Signature

Date

Name

Name of Personal Representative

Relationship to Patient