

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

1. **Authorization.** By signing this Authorization, I hereby authorize

(the Practice/Provider)

to discuss and/or disclose **to the person(s) named below** protected health information concerning my ongoing medical/surgical care: _____

2. **Purpose.** This Authorization is granted for the following purpose(s): **so that these members of my family may provide support and assistance in my continuing medical/surgical care.**

3. **Expiration Date/Event.** This Authorization is valid and shall remain in effect until rescinded in writing by myself.

4. **Limitations.** In addition to the above, the following is/are other criteria or limitations that I make regarding this Authorization: **NONE**

5. **Voluntary Act.** I expressly acknowledge that this Authorization is voluntary.

6. **Revocation.** I understand that this Authorization may be revoked by me at any time, provided that I submit a signed revocation form to the Practice's Privacy Officer. However, any revocation shall not apply to the extent that the Practice has taken action in reliance on this Authorization.

7. **Re-disclosure.** I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, and that the information will no longer be protected by the Practice or the HIPAA Privacy Rules.

8. **Copy of Authorization.** If the Practice has requested this Authorization from me, I understand that the Practice will provide me with a copy of this Authorization once signed by me.

Name of Individual (printed)

Signature of Individual

Signature of Personal Representative

Relationship

Date Signed ____/____/____

Witness: _____