

**AUTHORIZATION FOR TRANSFER
OF
PROTECTED HEALTH INFORMATION**

1. **Authorization.** I hereby authorize and request:

(Name of provider or practice)

to release all records of my medical/surgical care currently in your possession to:
(Indicate name of recipient provider/practice below.)

2. **Purpose.** This Authorization is granted for the following purpose(s):
the continuation of my medical/surgical care.

3. **Expiration Date/Event.** This Authorization is valid until the following event:

The provision of my complete medical records to recipient provider/practice indicated the original records or a copy.

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

The PHI disclosed may___ or may not___ include any HIV related information. (This MUST be completed)

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

6. **Pre-conditions.** I understand that the recipient may not condition the provision to me of treatment on my signing this Authorization.

7. **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.

8. **Re-disclosure.** I understand that the information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient, in accordance with the HIPAA Privacy Rules and the policies and procedures established by the recipient provider/practice.

Name of Individual (printed)

Signature of Individual

Signature of Personal Representative

Relationship (eg. Attorney-In-Fact,
Guardian, Parent of minor)

Date Signed ____/____/____

Witness: _____