AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:____ **Date of Birth: ____________________**

Last **First** **Middle**

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider Cynthia L. Post Ph.D. to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information ____.
Address of the recipient or where my health information should be delivered:
____.

Purpose: I understand that the specific purpose of this Authorization is
____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Term: This Authorization will remain in effect until (fill in expiration date – may not exceed on year).

Revocation: You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____

Signature Date

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

____

Name of Guardian/Representative Legal Relationship Date