

Section IV – Purposes for the Disclosure

----- At the request of the individual

----- Other: If you feel it is necessary to honor your wishes, you may attach a written explanation of the purposes for disclosing the information.

Section V – Expiration

----- This authorization expires in 30 days

----- This authorization expires on: ----- OR

----- This authorization expires with the following event: -----

Section VI – Required Statements

You have a right to revoke this authorization at any time as explained in the clinic’s Notice of Privacy Practices. You have the right to receive your own copy of the *Notice of Privacy Practices*.

The covered entity whom you are authorizing to disclose protected health information may not condition treatment, payment, enrollment or eligibility for benefits in the future on whether or not you sign or revoke this authorization.

You must understand that there is the potential for information disclosed pursuant to this authorization to be the subject of redisclosure by the recipient and no longer protected by the federal HIPAA regulation.

Section VII – Signature

I agree that a photocopy of this authorization may be accepted in lieu of the original.

Patient Name:

DOB:

Name of person requesting access if not the patient

Relationship to patient

Signature

Date of Signature