

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

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I hereby authorize the use and disclosure of my protected health information as described below. This authorization is voluntary and I understand that I may refuse to sign this authorization.

1. Person/Organization Authorized to Disclose Information:

\_\_\_\_\_

2. Person/Organization Authorized to Receive Information:

\_\_\_\_\_

3. Description of Information to be Disclosed (check all that apply):

Medical Records

Billing Records

Mental Health Records

Other: \_\_\_\_\_

4. Purpose of Disclosure:

\_\_\_\_\_

5. Expiration Date or Event:

\_\_\_\_\_

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I understand that I have the right to revoke this authorization at any time by providing written notice. I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Personal Representative (if applicable):

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_