

AUTHORIZATION TO \_\_\_\_\_  
(Name of Facility or Provider)  
TO DISCLOSE MY PROTECTED HEALTH INFORMATION  
TO OTHERS

1. I agree and hereby authorize the use or disclosure of my protected health information (“PHI”) by \_\_\_\_\_ in the following manner (this section to be completed, describing the PHI in a meaningful fashion with specificity, by the Facility or Provider, and the purpose for the use or disclosure):  
(Name of Facility or Provider)

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2. The following is a list of the person or persons (or their job type/title) at this Facility or Provider authorized to make the requested use or disclosure: \_\_\_\_\_

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3. The following is the name of the person or persons (or their job type/title) who may receive and use the requested PHI: \_\_\_\_\_

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4. I understand that I may refuse to sign this authorization.

5. I understand that I have the right to revoke this authorization. If I choose to revoke, I must do it in writing, and provide the revocation to this Facility or Provider in the following manner:

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6. I understand that my PHI that is used or disclosed based on this authorization may be further used and disclosed by the person who receives it.

7. I understand that \_\_\_\_\_ will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my executing this authorization except if: the disclosure is necessary to determine payment of a claim for specific benefits; and the authorization is not for use or disclosure of psychotherapy notes.

8. I understand that I have the right to a copy of this authorization.

9. This authorization shall expire on: (fill in with either a date certain, or an event (e.g., “the end of a research study”)) \_\_\_\_\_

\_\_\_\_\_  
Date

(if signed by a personal representative, please describe the representative’s authority):

\_\_\_\_\_  
Signature of individual

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