

**AUTHORIZATION FOR OBTAINING AND DISCLOSING
PROTECTED HEALTH INFORMATION**

Section A: This section must be completed for all Authorizations					
Patient Name:		Birth Date:		Social Security No. (optional):	
Provider's Name:			Recipient's Name:		
Provider's Address:			Recipient's Address:		
Provider's Phone Number:		Provider's's Fax Number	Recipient's Phone Number		Recipient's Fax Number
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
Date:		Event:			
Purpose of disclosure:					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Intake form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Laboratory tests		<input type="checkbox"/> Diagnostic tests <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Monitoring Strips <input type="checkbox"/> Itemized bill:		<input type="checkbox"/> HCFA-1500: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan, health care provider, healthcare clearing house or business associate of such health plan, health care provider or health care clearing house the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I may receive a copy of this form after I sign it.					
Section B: The request of PHI is for the purpose of marketing					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Patient Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	
Indicate authorized representative's authority to act on the patient's behalf: (circle one)					
o Parent/legal guardian		o Limited power of attorney			
o General power of attorney		o Other (Please describe): _____			