



PF 3000

\_\_\_\_\_  
Doctor Name

\_\_\_\_\_  
Office Address



**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**(Do Not Use This Form If Records To Be Released Relate to HIV Test Results, Mental Health or Alcohol/Drug abuse)**

EXPLANATION: This Authorization is necessary for us to comply with state and federal laws pertaining to the use or disclosure of protected health information (“PHI”) about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent us from acting on this Authorization.

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names: \_\_\_\_\_ Account #: \_\_\_\_\_

1. PERSONS AUTHORIZED TO DISCLOSE PHI. I authorize the following person(s) or class of persons to disclose the health information about patient as described in Section 2 below: *(State name of physician or specific identification of person or class of persons)* \_\_\_\_\_

2. DESCRIPTION OF INFORMATION. This Authorization permits the use and/or disclosure of the following information about patient: *(Check all applicable boxes and initial selection as required)*.

\_\_\_\_\_ (Initial) All my health information marked below pertaining to any medical history, physical condition and treatment received. Except *(optional)*: \_\_\_\_\_

Medical Office Records  Hospital Records  X-ray films & images  Laboratory Results

Or, only the following records or types of health information and/or only on the specified date(s):

Date(s) of Treatment: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_

\_\_\_\_\_ (Initial) Other \_\_\_\_\_

3. AUTHORIZED USERS AND RECIPIENTS. I hereby authorize the following person or class of persons to receive and/or use the health information described in Section 2 above: *(State name and title if applicable.)* **Name:** \_\_\_\_\_ **Title** (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

4. PURPOSE. I hereby authorize the information checked in Section 2 above to be used and/or disclosed for the following purposes: *(Check all applicable boxes)(Researchers should note that this must be research study specific, not for future unspecified research release)*

Requested by patient or personal representative.  Other: \_\_\_\_\_

Physician or practice will be remunerated for this information. Yes  No

5. RIGHT OF REVOCATION. I understand that I have the right to revoke this authorization at any time, providing that my revocation is in writing and conforms to requirements described in the ProHealth Partners/Argus Notice of Privacy Practices.
6. LIMITS TO REVOCATION. I understand that my revocation will be effective upon its receipt by the person(s) I authorized in Section 1 but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information described in Section 3, if patient (or personal representative) requested the Authorization, any revocation will be effective only when I communicate my revocation directly to them.
7. REDISCLOSURE. I understand that if the recipient of my information in Section 3 above is not a healthcare provider, a health plan or a health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.
8. CALIFORNIA RESTRICTIONS. I understand that a recipient of medical information in California may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.
9. RIGHT TO REFUSE TO SIGN. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment or benefits.
10. AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified.  
End date \_\_\_\_\_ Or Event \_\_\_\_\_
11. COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization \_\_\_\_\_ (Initials)

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship of Personal Rep. to Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone number

\_\_\_\_\_  
Type of pt./rep. ID presented. Attach copy (optional)

\_\_\_\_\_  
Verified Yes  No  Initials who verified \_\_\_\_\_

ATTENTION RECIPIENT: ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSE OF THIS DISCLOSURE
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