Authorization Form

For the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires on_____

Persons/organizations authorized to use and/or disclose the information:

_____

Persons/organizations authorized to receive the information:

_____

Specific description of information that may be used/disclosed:

_____

_____

The information will be used/disclosed for the following purposes:

_____

_____

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that the Department will not condition treatment, payment or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the Department in writing. However, the revocation will not be valid if:

a. The Department has taken action in reliance on this authorization; or
b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Please sign below.

_____ _____
Signature Date

_____ _____
Printed Name Notary Name & Seal

If the above signature is that of a patient representative, please attach the appropriate legal documentation.

For Department Use Only

If the above signature is that of a patient representative, complete the following:

The Department has verified the identity of the patient representative.

_____ _____
Signature /Title Date