

AUTHORIZATION OF TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Effective Date: February 17, 2026

I. Patient Information

Patient's Name:			
	Last	First	Middle

Home Address:	

Home Telephone:		Date of Birth:	
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II. Information to Be Disclosed

The information that may be disclosed under this Authorization includes:

MY HIGHLY CONFIDENTIAL INFORMATION: Without limiting the information specified above, by checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about mental health or developmental disability services
- Alcohol/drug abuse treatment program records and information
- HIV/AIDS test results
- Other:

III. Recipient

Name of person or class of persons to whom (the "Practice") may disclose my health information:

Address of the recipient or where my health information should be delivered:

IV. Term

This Authorization will remain in effect:

From the date of this Authorization until

Until Practice fulfills this request

Until the following event occurs:

V. Purpose

I authorize the Practice to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

VI. Important Information

I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes alcohol or drug abuse treatment program records or information, the confidentiality of the records or information is protected by federal law (42 C.F.R. Part 2) that prohibits re-disclosure except with my specific written consent.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Practice; except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

You may contact the Practice's Privacy Office by at:

Address:

Phone:

Email:

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

Signature of Patient

Signature

Date:

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Authorized Personal Representative

Relationship to Patient:

Date:
