

Rothman
Institute

THIS FORM IS NOT INTENDED AS LEGAL ADVICE, AND MAY NOT CONTAIN ALL ELEMENTS
REQUIRED UNDER STATE AND FEDERAL LAW.

AUTHORIZATION

Patient's name: _____

Patient's address: _____

Patient's date of birth: _____ OR social security no. _____

I hereby authorize disclosure of protected health information about me as follows:
(Facility or doctor) _____ is authorized to disclose medical information about me.

The information may be disclosed to:

(Name) _____

(Address) _____

The specific information to be disclosed is: _____

from: (date) _____ to: (date) _____

The purpose of the requested disclosure is: _____

I acknowledge that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV); sexually transmitted disease, tuberculosis or genetics. **IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL DO NOT RELEASE** _____

I have the right to revoke this authorization by written notice to _____

I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: (date) _____ or upon the following event: _____

✓ _____
Signature of patient or personal representative Date

If signed by a personal representative, a description of the representative's authority to act is as follows: _____