

# Authorization to Use or Disclose Protected Health Information

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address: \_\_\_\_\_

I am the patient, or the legally authorized representative of the patient, listed above.

- I am requesting a copy of my own records.
- I authorize the organization named below to release protected health information to GRRP:
- I request GRRP to release protected health information to:

Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Telephone: \_\_\_\_\_

State/Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

Purpose:  Continuing Care  Insurance  Legal  Social Security/Disability

Transfer Care  Other: \_\_\_\_\_

Delivery Method:  Pick-up  Mail  Fax (Hospital or Physician Office only)

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this limited authorization in writing at any time at the address on the top of this form, except the extent that action has been taken in reliance on this authorization. This authorization is in effect until revoked by me or until it expires. Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

\_\_\_\_\_  
If I do not specify an expiration date, event, or condition, this authorization will expire in twelve months.

Redisclosure: If the person or entity that receives the information is not a healthcare provider or health plan, covered by federal privacy regulations, I understand the information described above may be redisclosed and no longer protected by these regulations.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date Time

\_\_\_\_\_  
License copied/ID checked – Staff Initials Date Time

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right. Examples of these documents include Letters of Representation, Guardianship Papers, and Affidavits of Heir at law, etc.