CS-1786
Rev 5/2004

HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name _____

I hereby authorize _____ to use or disclose my
(Discloser)

protected health information related to _____
(Type of Information)

to _____ for the following purpose:
(Recipient)

_____

_____

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Date Signature of Individual or Representative

_____
Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on _____
If no date or event is stated, the expiration date will be six years from the date of this authorization.

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.