



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. Authorization:

You may use or disclose the following Health Information (check all that apply):

- All Health Information in my medical record;
- Health Information in my medical record relating to the following treatment or condition:

Health Information in my medical record for the date(s): _____

Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose Health Information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this Health Information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____

Authorization Expiration: *(This Authorization does not permit disclosure of Health Information more than 90 days after the date it is signed.)*

in 90 days from the date signed

on (date): _____

when the following event occurs: _____

(no longer than 90 days from date signed)

II. My Rights:

I understand I do not have to sign this authorization in order to receive health care. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the District based on this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the District, or
- Write a letter to the District

Once Health Information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)