Authorization for Use/Disclosure of Protected Health Information

Client Name: ________________________________ Birthdate: ___________________

Release of Protected Health Information

My protected health information may be disclosed to the following:

Name: ____ **Facility**: ____

Phone: ____ Fax: ____

Address: ____

Name: ____ **Facility**: ____

Phone: ____ Fax: ____

Address: ____

Name: ____ **Facility**: ____

Phone: ____ Fax: ____

Address: ____

Name: ____ **Facility**: ____

Phone: ____ Fax: ____

Address: ____

Signature required for release/obtain/exchange for information. **I understand that by signing below:**

- I authorize HSDC to release protected health information to the parties listed above.
- I authorize HSDC to release any information required to insurance companies, medical providers, and other as required by law or court order.
- I understand that in order to revoke these rights, a written notification must be submitted to HSDC.
- Authorizing the disclosure of health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.

____ ___________________

Signed name of patient/personal representative

Date

____

Printed name of patient/personal representative

Revision date: 3/25/16