AUTHORIZATION
For the Use or Disclosure of Health Information

Patient Identification

_____ Birth Date: _____

Address: _____ Phone: _____

City/State/Zip: _____

Maiden/Previous Names/Nickname: _____

Social Security Number: _____

Provider
(Who is releasing information?)

Provider/Facility Name: _____

Address: _____Phone: _____

City/State/Zip: _____

Disclose Information To:
(Where is information to be sent?)

Provider/Facility Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax:_____

To assure confidentiality, DFMC will transmit records via facsimile only when requested and expressly authorized by the patient.

Information to be Disclosed

Specific description of the health information that may be used or disclosed:
_____

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above name patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of Patient/Guardian/Representative Date

_____
(Relationship to patient, if signed by representative)

Please supply proof of authority to act. For minors, proof only required if other than parent.

Disposition

Name:

_____

For office use only:

Date Sent: _____ Sent by: _____