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Samuel N. Crosby, MD
A. Brian Thomson, MD
Amanda D. Martin, DO
Brian D. Dierckman, MD

Authorization for Use/Disclosure of Protected Health Information

Patient Name:________________________________ DOB:_______________________

I hereby voluntarily authorize the use/disclosure of information from my health record.

The information is to be disclosed by: _______________________________________
Practice

The information is to be provided by: ____
Name of Person/Organization/Facility

____
Address/Email/Fax

The purpose of this disclosure is:

☐ Medical Care ☐ Attorney ☐ School/Work ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (specify) ______________________

The information to be disclosed from my health record: (check appropriate box)

☐ Entire Medical Record
☐ Only information related to (specify) ___________________________________
☐ Only dates of service from ____________________ to ____________________
☐ Other (specify) ____

I understand I have the rights to revoke this authorization by submitting my request in writing at any time to the Practice. The Practice must comply with my request except to the extent that action has been taken in reliance of this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or policy of insurance, other law may provide the insurer with the right to contest to claim under the policy.

This authorization expires: (specify date/event) ________________________________
I understand that the Practice will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature of Patient: ____________________________________ Date: ____________
Name of Personal Representative (if applicable): _________________________________
Signature of Personal Representative: Date: ____________________________________
Relationship to Patient: ____

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