



Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

Summit View Clinic may use or disclose the following health care information (check all that apply):

All health care information in my medical record

Medical records relating to the following treatment, dates or condition: _____

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

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

HIV/AIDS

Sexually Transmitted Diseases

Mental Health or Illness

Drug and/or Alcohol Abuse

Reproductive Care (minors only)

Minors – a minor patient’s signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address (optional): _____ City: _____ State: ____ Zip: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

at my request

other (specify) _____

This authorization ends:

on (date): _____ when the following event occurs: _____

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Summit View Clinic in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
 - Fill out a revocation form or write a letter to Summit View Clinic.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Signature _____ Date _____

Patient or legally authorized individual signature (Printed name if signed on behalf of the patient)