

Authorization for Use and Disclosure of Protected Health Information

Type of Information to be Disclosed: I, _____ (client name) hereby authorize Connie Chapman, MSW, to use and/or disclose protected health information:

- Records – outside health provider
- Other _____

Each Purpose for Use and/or Disclosure:

Recipient of Protected Health Information:

Addressee(s)		Business, Agency, Other			
Business Phone	Address	City	State	Zip	

Deliver By:

- Mail or Courier
- Fax (____) _____
- Telephone (____) _____
- Email _____
- In Person _____

Revocation/Redisclosure: It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already occurred in reliance on this authorization, including provision of health care services requiring disclosure to effectual payment. Unauthorized redisclosure by recipient is a potential risk.

Duration: If not previously revoked, this authorization will expire:

(must specify date, event, or condition)

Specific Limitations: Except as to third party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from the date of the last signature.

Signature: This authorization covers protected health information pertaining to _____

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of that signature (initial or renewal). I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits.

Initial Signature *Date*

Witness *Date*

Renewal Signature *Date*