

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:	DATE OF BIRTH:
ADDRESS:	SOCIAL SECURITY NUMBER:

I hereby authorize Express Care of the Shoals to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

Use the following health information maintained by Express Care until:

Expiration Date/ will expire one year from signed date unless otherwise specified above.

DISCLOSE the following health information to:

To: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

OBTAIN the following health information from:

To: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Specific description of the health information to be used/disclosed/obtained (*include dates and type of service*).

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*):

By providing this Authorization, I understand as follows:

- I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.
- I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
 - The treatment is related to research and the use and/or disclosure is related to such research; or
 - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
- I understand that Express Care will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
- I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.
- I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
- I understand that I may revoke this Authorization at any time by notifying Express Care in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
- Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.
- I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
- I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative (*if applicable*)

Representative's Relationship to Patient (*if applicable*)