AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You may decline to sign this Authorization

I,_____, hereby authorize_____(hereafter collectively referred to as "Agency") to use and disclose in any form or format, a copy of records concerning (PRINT client/patient) _____but only as follows. A copy of this signed, dated Authorization shall be as effective as the original.

Agency may use and disclose the following information.

To: _____

For the purpose(s) of (be specific):

I specifically authorize Agency to use and disclose the following types of confidential information (initial where appropriate):

_____HIV records (including HIV test results) and sexually transmissible diseases

_____Alcohol and substance abuse diagnosis and treatment records

_____Psychotherapy records

_____All records as necessary

_____Other: Specify:_____

The undersigned does hereby release, hold harmless and agree to indemnify Agency, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until Agency is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that the Agency has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization.

Patient Signature:_____Date:_____
OR

Patient's Representative:_____Date: _____

(Print name and describe authority):

_____

Agency Representative Signature & Title:_____Date: _____