GUTHRIE℠

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
(Read Entire Document Before Signing)

Patient Name: _____ Maiden/Previous Name: _____
Date of Birth: _____ Social Security #: _____ Medical Record #: _____
Address: _____
(Street) *(City)* *(State)* *(Zip)*

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
   Name: _____
   Address: _____
   (Street) *(City)* *(State)* *(Zip)*

3. Description of information to be used or disclosed:

Description:	Date(s):	Description:	Date(s):	Description:	Dates(s):
☐ Discharge Summary		☐ Emergency Department		☐ Clinic Notes	
☐ History/Physical		☐ Physical Therapy		☐ Immunization Records	
☐ Operative Reports		☐ X-ray Reports		☐ Lab Results	
☐ Cardiac Cath Reports					
☐ Other					

4. This information may be disclosed to and used by the following individual or organization:
   Name: _____ Telephone: _____
   Address: _____
   (Street) *(City)* *(State)* *(Zip)*

5. Purpose of disclosure:
   _____ My personal records (Charge not to exceed state maximum)
   _____ Sharing with healthcare providers as needed
   _____ At the request of my attorney – Attorney's Name _____
   _____ Other (please describe) _____

6. I understand that:
   1) I may refuse to sign this authorization and that it is strictly voluntary.
   2) My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
   3) I may revoke this authorization at any time in writing, but if I do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
   4) Once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.
   5) I may see and obtain a copy of the information described on this form, for a reasonable copy fee.

7. This authorization will expire six months from the date of signature unless you request an earlier date or event.
   Expiration Date: _____ Event: _____

8. **Specially protected information** (please check all that apply):

   ☐ I understand that the information to be disclosed may include information relating to AIDS or HIV.
   ☐ I understand that the information to be disclosed may include information relating to psychiatric or other mental health treatment.
   ☐ I understand that the information to be disclosed may include information about treatment for drug, alcohol, or substance abuse.

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signature of Patient/Guardian: _____ **Date:** _____

Photo ID required for records to be picked up.

Witness to ID: _____ **Relationship to Patient:** _____