**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the release of my protected health information only in the specific manner outlined below (check all that apply). **I understand that this authorization will allow the release and use of sensitive information, potentially to include mental health, HIV, AIDS, substance abuse, and/or other related conditions.**

□ Dr. Benzick may **obtain** information from another health care provider, individual or corporate entity:

Name of person or organization releasing information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Information **Requested**:

□ Dr. Benzick may **release** information to another health care provider, individual or corporate entity:

Name of person or organization receiving information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific Information **to be Released**:

Dates Covered by this Authorization: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This authorization provides that**

● I may revoke this authorization at any time, provided that the revocation is in writing.

● Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this authorization or HIPAA privacy rules.

● This practice will not normally condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for disclosure. However, in specific circumstances (e.g. substance abuse treatment, repeated suicidal thinking) Dr. Benzick may require the ability to communicate medical information to family if, as a licensed physician working in my best interest, he feels it is necessary.

● I have a right to access my protected health information to be used or disclosed.

● I will receive a copy of this completed and signed form upon request.

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Signature of Patient or Representative named above Date