

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name	Date of Birth	Social Security Number
Address (Street, City, State, and Zip Code)		Telephone

The following individual or organization is authorized to make the disclosure:

- Family Health Center of Montclair
- Other (please specify) _____

This information may be disclosed to and used by the following individual or organization:

- Family Health Center of Montclair
- Other (please specify name and address) ** _____

** Fee of \$1 per page may be assessed (\$10 minimum, \$100 maximum)

Specific Date(s)	Purpose of Request
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The following information is to be disclosed: *(please check one box for each item)*

- | | | | |
|--|----------------------------------|--|------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Office / physician Notes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lab Results |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Immunization Record | <input type="checkbox"/> Yes <input type="checkbox"/> No | X-Ray Reports |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Consultation Letters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospital Reports |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Old Records (previous physician) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Complete Record |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | | |

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV).

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: *(If I do not specify an expiration date, event or condition, this authorization will expire in 6 months.)*

Signature of Patient or Legal Representative	Date
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Relationship to Patient, if signed by Legal Representative