



7.32 Patient Authorization for Disclosure to Designated Provider

Please print all information, then sign and date form at bottom.

Type of Authorization: Designated Provider

Charge _____

Patient Name _____

Patient Social Security Number _____ **Patient Date of Birth** _____

Purpose of request – I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

Provider Receiving Records	Provider Releasing Records
Name of practice	Name of practice
Name of provider	Name of provider
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone

Description of information to be disclosed – I authorize the disclosure of the following protected health information about me to the person(s) identified above:

___ Complete medical record; or

___ Only the following information:

Purpose of disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

___ Patient Request

- **Expirations or termination of authorization** – This authorization will expire within 14 days from the date of my signature below.
- **Right to revoke or terminate:** As stated in our Notice Privacy Practices, you have the right to revoke or terminate this authorization.
- **Redisclosure:** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.
- **No conditions:** Your signature on this authorization does not condition your treatment, payment or eligibility for benefits.

Patient or Responsible Party Signature

Date