AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use and disclosure of my individually identifiable health information as described below; I understand that this authorization is voluntary. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by the federal privacy regulations.

Patient Name: _____(Print) **DOB: _____**

ID Number or SSN: _____

Specific description of information to be used or disclosed:

Please send records for the last six (6) months only unless there are specific circumstances.

Purpose of use or disclosure of health information: _____

Persons/Organizations authorized to release the information:_____

Persons/Organizations authorized to receive the information: _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol/drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

I understand that this authorization will expire _____ OR at the following described event that relates to the purpose of disclosure.
Describe event: _____

I understand that I may revoke this authorization at any time by notifying my physician in writing at Cockrell Family Medical Center, P.C., but if I do revoke my authorization, my revocation is not effective to the extent my physician has relied on this Authorized before receiving my revocation.

I understand that my physician will not condition my treatment, payment, or enrollment in a health plan on whether I provide authorization for the use and disclosure described above except:

- If my treatment is related to research
- If healthcare is provided to me solely for the purpose of creating protected health information for disclosure to a third party

I understand that there may be a fee for preparing and furnishing this information.

Patient/Representative Signature: _____ Date: _____

Printed name of patient's representative: _____

Relationship to patient: _____

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Please do not FAX more than 20 pages