

SPECIAL AUTHORIZATION FORM

(Name of Practice)

Patient Authorization for Special Use and Disclosure of Protected Health Information

(For purposes other than routine treatment, payment, or health care operations)

By signing, I authorize this medical practice to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits this medical practice to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed:

- at my request _____
- or for the following purpose:

The purpose(s) is/are stated so that I can make an informed decision whether to allow release of this information. This authorization will expire on:

(date or defined event) _____

This medical practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from this medical practice, and I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing unless the practice has already acted in reliance upon this authorization. My written revocation must be submitted to the "Privacy Officer" at this medical practice.

Signed (Patient or Parent/Guardian): _____ (Date) _____

(Original signed authorization to be filed in Patient's chart.)

(Patient/Parent/Guardian must be provided with a copy of this form.)