

APPENDIX G-1

Sample Authorization Form to Use and Disclose Health Information

Individual's name:

Date of Birth: _____

Individual's address:

Individual's ID#: _____

I hereby voluntarily authorize the use and disclosure of my protected health information as described below:

1. Specific Description of the Information to be Used or Disclosed:

The above information will be called "Authorized Information" throughout the rest of this form.

2. Person (or class of persons) Authorized to Make the Use or Disclosure of Authorized Information:

3. Person (or class of persons) to Whom the Use or Disclosure of Authorized Information May Be Made:

4. Authorized information will be used and/or disclosed for the following purpose(s):

5. This authorization expires: _____

6. Furthermore, by signing below, I understand that:

- my personal information will be released to the person or class of persons listed above;
- this information may include information regarding mental health, drugs & alcohol, HIV/AIDS and other communicable diseases, and/or genetic testing (unless specifically excluded above);
- I may revoke this authorization by a written notification of my desire to revoke it to the medical provider named in number 2 above;
- any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions;
- the medical provider named in number 2 above may not condition its treatment of me on whether or not I sign this authorization; and
- information released may no longer be protected by federal privacy regulations.

Individual's Signature _____ Date: _____