Patient Authorization for Use/Disclosure of Protected Health Information

Patient's name:_____ Date of birth: _____
SSN:_____ Previous name _____

I request and authorize **Dena Petersen, M.D., P.C.** to release healthcare information of the patient named above to:

Name: _____
Address: _____
City, State, Zip: _____

This request and authorization applies to:
___ Healthcare information relating to the following treatment, condition, or dates of treatment:
_____
_____

___ All healthcare information
___ Other:_____

The protected health information will be used and/or disclosed for the following purposes:
_____ At the request of the individual.
Other_____
I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

In addition to the general authorization to release records to the persons or entities listed above, I authorize the release of the records described as the following:

Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases.	☐ Yes	☐ No
Drug and alcohol treatment.	☐ Yes	☐ No
Psychological/psychiatric information, including diagnosis and treatment.	☐ Yes	☐ No

I may revoke this authorization to the extent allowed by law. If I do, I understand that Dena Petersen, M.D., P.C. may have already released information about me after I gave permission. I **understand that** I **cannot revoke this authorization retroactively for information already released.**

There are two ways to revoke this authorization. I can:

1) sign and date a form available from Dena Petersen, M.D., P.C. called "Revocation of Authorization for Use and Disclosure of Healthcare Information"; or,

2) write a letter lo Dena Petersen, M.D., P.C. If I write a letter to Dena Petersen, M.D., P.C., it must say that I want to revoke my authorization to disclose the patient's healthcare information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative for healthcare) must sign and date the letter.

Once **Dena Petersen, M.D, P.C.** gives out the information that I want released, I know that Dena Petersen, M.D., P.C. has no control over the information, The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the Information.

_____
Signature of patient or patient's authorized representative Date signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)
This authorization expires on _____ or when the following event occurs

_____