

**MODEL AUTHORIZATION**

**FOR THE USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (PHI)**

I authorize the use and/or disclosure of my protected health information (PHI) as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. I authorize the following persons (or class of persons) to receive my protected health information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing (in the form of a letter). I am aware that my revocation is not effective to the extent that the persons I have authorized to use and or/disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon \_\_\_\_\_ (*insert date or an event that triggers expiration*).

7. I further understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing an authorization.

I hereby certify that I have received a copy of this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient