

[PRACTICE NAME]

[Address] · [Phone] · [Privacy contact email]

Authorization to Use or Share My Health Information

Use this form to let us share your health information with someone, or use it for a purpose, that the law does not otherwise allow without your permission. Please review every section, complete your details and choices, and ask us if anything is unclear before signing.

Mark your choices with an X.

1 About you

Full name	
Date of birth	
Other names used (optional)	
Phone or email (optional)	

2 Who may share the information, and who may receive it

45 CFR 164.508(c)(1)(ii)–(iii)

Who may share it	PRACTICE NAME and its staff
Other (if any)	
Who may receive it — name	Person or organization
Address	
Phone, email or fax (optional)	

3 What information may be shared

45 CFR 164.508(c)(1)(i)

Please describe the information clearly. Check all that apply.

☐ Treatment notes from date to date	☐ Medication list
☐ Imaging reports	☐ Billing and payment records
☐ Radiographs, photos or scans (say which)	☐ Details or other (be specific):

Sensitive information. Some laws give extra protection to certain kinds of information. It will be shared **only if you initial** next to it. Initials do not replace a separate authorization or consent where the law requires one. Ask us before including psychotherapy notes or records protected by 42 CFR Part 2.

Mental health information (not psychotherapy notes)	Initials
HIV/AIDS and sexually transmitted infection information	Initials
Genetic testing information	Initials
Reproductive health information	Initials
Substance use disorder information	Initials

4 Why the information is being shared

45 CFR 164.508(c)(1)(iv)

- ☐ At my request
- ☐ Legal matter
- ☐ Insurance application or claim
- ☐ Employment or school form
- ☐ Other:

5 When this authorization ends (choose one)

45 CFR 164.508(c)(1)(v)

- ☐ On this date:
- ☐ One year from the date I sign
- ☐ When this event happens:

6 Please read before signing

45 CFR 164.508(c)(2)

- You can cancel this authorization.** You may revoke it at any time by writing to **PRIVACY CONTACT NAME**, **ADDRESS OR EMAIL**. Revoking does not undo anything we already did in reliance on it, and it may not apply if this authorization was a condition of getting insurance coverage and other law gives the insurer the right to contest a claim. Our Notice of Privacy Practices also explains how to revoke.
- Your care does not depend on this form.** We will not condition your treatment, payment, enrollment in a health plan or eligibility for benefits on whether you sign it.
- Information may be shared again.** Once information is shared under this authorization, the person or organization that receives it may share it again, and it may no longer be protected by federal privacy rules.
- You will get a copy** of this form after you sign it.

7 Signature

45 CFR 164.508(c)(1)(vi)

Signature	
Date	
If signed by a personal representative — name	
Relationship and authority to act	For example parent of a minor, legal guardian, health care agent

OFFICE USE ONLY — USE THIS FORM ONLY WHEN SIGNING IS VOLUNTARY

Date received	
Identity verified by	
Copy given to patient (date)	
Expiration date entered in record	

Keep this signed form for at least six years from the date it was signed or last in effect, whichever is later.