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Authorization for Use or Disclose of Protected Health Information

To: _____ (Provider/Clinic)

I, (name): _____ DOB: _____,
herby authorize the release of protected health information about me. The specific information and purpose I am authorizing this release are the following:

_____

The recipient of this information is to be: **Christine Rummer Copeland PhD**

The information is to be transmitted by: _____

I am aware that my records may contain health care information relating to testing, diagnosis, or treatment for HIV/AIDS or for any other STD, for chemical dependence, and/or mental health. My initial below indicates my intention to release that information.

_____ HIV/AIDS _____ Sexually Transmitted Diseases

_____ Chemical Dependency _____ Mental Health

I understand that I may revoke this authorization in writing at any time; that the provider will make a Revocation of Authorization form available to me; that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I understand that the Department of Social and Health Services' certified drug and alcohol programs will honor verbal revocations upon authenticating my identity.

I understand that re-disclosure of my health information by the Recipient, if unauthorized is a potential risk. If re-disclosed, privacy laws may no longer protect the information. I understand that I do not have to sign this authorization in order to obtain treatment benefits from the Provider, except for health care services necessary to create any assessment or report contemplated by this authorization. I understand that I am entitled to a copy of any authorization I sign.

The effective date of this authorization will be the date of my signature below. If not previously revoked, this authorization expires in 90 days or upon the following date: _____ , or upon the following event: _____.

_____

_____ _____

Signature of Patient (or Parent or Legal Guardian) Date