## *B. Authorization to Use/Disclose Protected Health Information (HIPAA)*

Name: _____
Location: _____ Telephone Number: (___)_____

I hereby authorize the use and/or disclosure of my health information as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by the federal privacy regulations.

1. Person or organization authorized to disclose the health information:
   _____

   _____

2. Person or organization authorized to receive the health information:
   _____

   _____

3. Description of health information that may be used/disclosed:
   _____

   _____

4. Description of each purpose for which the health information will be used/disclosed (***Note***: *Not required if disclosure is requested by the individual*):
   _____

   _____

5. I understand that the person or organization that I am authorizing to use/disclose the information may receive compensation in exchange for the health information described above.
   _____

   _____

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits.* (*Note*: *Not required if disclosure is requested by the individual*).
   _____

   _____

7. I understand that I may revoke this authorization at any time by providing written notice to:
   _____

   _____

   I understand that my revocation will not affect any actions already taken in reliance on this authorization.

8. I understand I may inspect or copy any information to be used or disclosed under this authorization.

9. Unless otherwise revoked in writing, this authorization will expire _____ days from the date signed below. If this date is left blank, the authorization will automatically expire one year from the date I sign below.

Signature of Individual (or Legal Representative) Date

Individual's Name (Print)

Name of Legal Representative, if applicable (Print) Relationship

*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).