POWERS MEDICAL
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

I understand that Powers Medical will not condition treatment, payment, enrollment, or eligibility for benefit on my providing or refusing to provide this authorization.

I hereby authorize:

Name of Disclosing Party

Address

City State Zip

Phone Fax

To disclose to:

Name of Recipient

Address

City State Zip

Phone Fax

Records and information pertaining to:

Name of Patient (List other Names Used Date of birth

Address Telephone Number

Duration: This authorization shall become effective immediately and shall remain in effect for One year from the date of signature unless a different date is specified here _____.

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon the authorization.

Redi-Closure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specific Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

☐ **All Medical Information** _____ (Initial)

☐ **Health Information Related to:** _____

☐ **Other (designated report to specialist or other)** _____

Specify the records to be disclosed: _____

The recipient may use the health information authorization on this form for the following purposes: _____

Signature Date If signed by other than patient/ Indicate Relationship