Section: Privacy Policy	**Number**	P-108
Subject: Authorization for the Use and Disclosure of PHI	**Effective Date**	4/14/03

AUTHORIZATION
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

1. Organization (s) or person (s) allowed to release the information indicated by this form:

   _____

2. Organization (s) or person (s) to receive my health information as indicated by this form:

   _____

3. Specific description of the health information that may be used or disclosed:

   _____

4. The information will be used or disclosed for the following purpose (s):
   ___ At the request or direction of the undersigned individual
   ___ For marketing: The disclosing organization ☐ will ☐ will not receive compensation, monetary or otherwise, as a result of this use or disclosure.
   ___ Other: _____

   _____

5. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer be protected by the federal privacy regulations.

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

7. I understand that I may revoke this authorization at any time by written notification. However, the revocation is not valid if:
   - Action was previously taken in reliance on this authorization; or
   - This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

8. This authorization expires:
   ___ The following date: _ _ / _ _ / _ _ _ _
   ___ When the following event occurs: _____
   ___ No expiration (only for authorizations used to create or maintain research databases or repositories)

_____
Patient Name

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

_____ _____
Signature of Patient or Personal Representative Date

_____
Witness/Organization Representative