



I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event that I refuse to authorize release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will automatically terminate 60 days from the date signed unless otherwise specified.

(Specify) \_\_\_\_\_  
*Specific Termination Date*

\_\_\_\_\_  
*Signature of the Patient or Legal Representative* *Date*

\_\_\_\_\_  
*If you are not the patient, specify your relationship to the patient*

\_\_\_\_\_  
*Signature of Witness* *Date*

|                            |                        |                       |
|----------------------------|------------------------|-----------------------|
| <i>FOR OFFICE USE ONLY</i> |                        |                       |
| <i>Date Received</i> _____ | <i>Date Sent</i> _____ | <i>Initials</i> _____ |