



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize: _____ to use and/or disclose

protected health information (PHI) about me to: _____ (Recipient name)

(Recipient address or fax number/telephone number)

Reason for request of records:

- Moving out of area, Desire 2nd opinion, Financial dispute with Cooper Clinic, Specialist not available at Cooper Clinic, Prefer specialist outside Cooper Clinic, Unhappy with care by Dr., Other, Legal, Social Security Disability Claim, Personal Injury, Worker's Compensation, Malpractice, Bankruptcy, Insurance Eligibility/Benefits

The treatment dates covered by this authorization are from: _____ to _____

The information to be released is confined to the following:

Box containing checkboxes for Physician Notes, Procedure Reports, Laboratory Data, Radiology Reports, EKG/EEG, Consultations, Verbal Communication, Discharge Summary, History and Physical, Other, and Copies of records from: _____ which were added to my records at this institution for my continuing care needs. Psychotherapy notes cannot be re-released by this institution.

The clinic __ will __ will not receive compensation from another institution in exchange for using or disclosing the PHI.

The consent will automatically expire 90 days from the date signed, or on _____ (Expiration Date or Defined Event)

I understand that I do not have to sign this consent to receive treatment from this clinic. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, to the Cooper Clinic Director of Medical Records, except to the extent that action has already been taken in reliance upon this authorization.

Patient Signature

Phone Number of Patient

Printed Name of Patient

Witness Signature

Date of Birth

Date and Time Signed

Signature of Parent or Legal Guardian