

**AUTHORIZATION FOR FACILITY TO USE OR DISCLOSE INFORMATION
FOR ITS OWN PURPOSES**

The information found in this document is for informational purposes only. The information provided is not to be used or construed as legal interpretation.

Patient hereby authorizes General Hospital (“Facility”) to use or disclose [**specific description of the information to be used or disclosed**] (“protected health information”) maintained by Facility to [**name of person(s) or class of persons to whom Facility may make the requested use or disclosure**].

The Facility seeks to use or disclose the protected health information for the following purpose(s): [**description of each purpose of the requested use or disclosure**].

Patient hereby acknowledges that he/she understands that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on his/her signing of this Authorization. However, Facility may condition the provision of health care that is solely for the purpose of creating protected health information on Patient’s signing of this Authorization, and Facility may condition the provision of research-related treatment on Patient’s signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual..

Patient may inspect or copy the protected health information to be used or disclosed.

Patient may refuse to sign this Authorization if he/she so chooses.

[If Facility will receive payment, directly or indirectly, for the use or disclosure, must include a statement that such payment will result.]

[If Facility creates protected health information for the purpose, in whole or in part, of research that includes treatment of individuals, authorization must include the following:]

The Facility seeks to create protected health information for the purpose, in whole or in part, of research that includes the treatment of individuals. The Facility shall use or disclose such protected health information [**description of the extent**] to carry out treatment, payment, or health care operations.

The Facility shall not use or disclose [**describe the protected health information**] for the following purposes: [**includes uses or disclosures otherwise permitted, such as in connection with facility directories; involvement of others in the individual’s care; notification of family or personal representatives regarding the individual’s condition; public health activities; victims of abuse, neglect or domestic violence; health oversight activities; judicial or administrative proceedings; law enforcement purposes; organ donation purposes; or to medical examiners and funeral directors.**]

[If the Facility also obtained or intends to obtain the patient’s consent, or has provided or intends to provide the individual with a Notice of Privacy Practices, this Authorization must refer to that consent or notice and state that the statements in this Authorization are binding.]

[NOTE: These provisions do not apply to information for which (i) a board-approved waiver of the authorization has been sought; (ii) disclosure is sought solely for review to prepare a research protocol or other similar purpose; or (iii) disclosure is sought solely for research on the information of decedents and is necessary for the research.]

The Facility may use or disclose such protected health information only until [expiration date or expiration event relating to the individual or purpose of the use or disclosure].

At all times, Patient retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization. Patient may revoke this Authorization by [describe how Patient may revoke; e.g., where to send a written notice].

Patient has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED [SEALED SIGNATURES ARE OPTIONAL] DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

_____(SEAL)

Signature of Patient

Please print name

_____(SEAL)

Signature of witness

_____(SEAL)
Person Signing on behalf of Patient*

Please print name

Please print name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of Patient:

