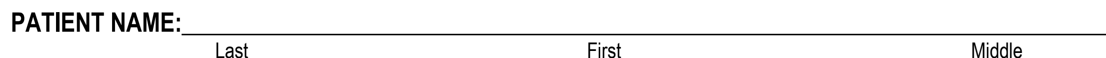
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION



PATIENT NAME:____

Last First Middle

Date of Birth: _______________ Home Telephone: _________________________________

Home Address: ____

SPECIFY INFORMATION TO BE DISCLOSED:

☐ All health information (excludes highly confidential information unless otherwise noted in the section below)

☐ Other:____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes below, I **specifically** authorize the use and/ or disclosure of the type of highly confidential information indicated next to box, if any such information will be used or disclosed pursuant to this Authorization:

____ Information about a Mental Illness or Developmental Disability
____ Psychotherapy Notes
____ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
____ Information about Venereal Disease(s)
____ Information about Substance (i.e., alcohol or drug) Abuse
____ Information about Abuse of an Adult with a Disability
____ Information about Sexual Assault
____ Information about Child Abuse and Neglect
____ Information about Genetic Testing

RECIPIENT:

I hereby authorize and request Alesia W. Griffin, M.D., P.C., 1413 Kempsville Road, Chesapeake, VA 23320, **to obtain information from and release information to**:

____

(fill in the name of the authorized person(s) or class of persons)

TERM:

This Authorization will remain in effect:
___ From the date of this Authorization until the _________ day of _________, 20___.
___ Until revoked by me in writing
___ Other:____

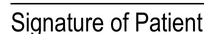
I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment or me; except, however, if my treatment at the Practice is for the sole purpose of creating health
information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Office at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.

I may contact the Practice's Office Manager by mail at the address, 1413 Kempsville Road, Chesapeake, VA, 23320, or by telephone at (757)366-0692.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use of disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily authorize the Practice to use or disclose my health information in the manner described above.



______________________________ ________________

Signature of Patient Date