# Authorization to Use or Disclose Protected Health Information

PRAIRIE STAR Health Center
non-profit • FQHC

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that once information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

| PATIENT INFORMATION | | | |
|---|---|---|---|
| LAST NAME | FIRST | | MIDDLE |
| ADDRESS | CITY | STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | | DATE OF BIRTH |

| PERSON(S) OR FACILITY TO *SEND* INFORMATION | | | PERSON(S) OR FACILITY TO *RECEIVE* INFORMATION | | |
|---|---|---|---|---|---|
| NAME | | | NAME | | |
| ADDRESS | | | ADDRESS | | |
| CITY | ST | ZIP | CITY | ST | ZIP |
| PHONE | FAX | | PHONE | FAX | |

**THIS INFORMATION WILL BE USED FOR:**

- ☐ **sharing with other health care providers (as needed)**
- ☐ **other (please describe):**

**INFORMATION TO BE DISCLOSED**

| DOCUMENTS | CHECK IF REQUESTED | TREATMENT DATE(S) |
|---|---|---|
| **Office Notes** | ☐ | LAST 5 OFFICE VISITS |
| **Hospital/ER Records** | ☐ | MOST RECENT |
| **Surgery/Op Notes** | ☐ | MOST RECENT YEAR |
| **Immunization Records** | ☐ | ALL |
| **Lab/Path/Micro** | ☐ | MOST RECENT YEAR (HIV & HEPATITIS IF OLDER THAN A YEAR) |
| **Diagnostics/Radiology** | ☐ | MOST RECENT YEAR |
| **PAP Smear and HPV** | ☐ | ALL |
| **Mammogram** | ☐ | ALL |
| **Colonoscopy** | ☐ | ALL |
| **Other:** | ☐ | |

**The information disclosed may include matters regarding mental health, alcohol or drug abuse and infectious diseases, including AIDS or HIV test results. Such information may be subject to special protections. If you do not wish such information to be released, list information to be excluded here:**

**I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if do, it will not have any affect on any actions taken before the revocation was received. Unless revoked, this authorization expires 1 year from the date signed below unless otherwise requested here:**

**I have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.**

**A faxed or photocopy of this authorization shall be considered valid. I give permission for this information to be faxed if necessary.**

| SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | DATE |
|---|---|
| IF SIGNED BY LEGAL REPRESENTATIVE, PLEASE STATE RELATIONSHIP TO PATIENT | |