_____

(Physician or Specialty) **Cannot state Dothan Specialty Clinic**

## Patient Authorization for Use and/or Disclosure of Protected Health Information

| **Patient Name:** | **Date of Birth:** |
|---|---|
| **Address:** | **Social Security or Account Number:** |

I hereby authorize _____ (Physician or Specialty) to use, disclose and/or obtain the above-named patient's health information as follows (check all that apply):

☐ use the following health information maintained by

_____ until:
(Physician or Specialty)

_____
Expiration Date/ will expire one year from signed date unless otherwise specified above.

☐ disclose the following health information to: (Name & address of person to receive information)

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

☐ obtain the following health information from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc.):* _____

_____

_____

This health information is used/disclosed/obtained for the following purpose *(if Authorization requested by the patient put: "At the request of the individual")*:_____

_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**

2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:

   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.

3. I understand that _____ **(Physician or Specialty)** will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.

4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.

5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.

6. I understand that I may revoke this Authorization at any time by notifying _____ **(Physician or Specialty)** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.

7. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.

8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative *(if applicable)*

_____

Representative's Relationship to Patient *(if applicable)*

**Dothan Specialty Clinic**

**4300 West Main Street, Suite 102, Dothan, Alabama 36305**

**Phone: (334) 793-9564 Fax: (334) 712-4280**

You are entitled to a copy of this Authorization after you sign it. This Authorization will be filed in the individual's medical record.