

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE  
OF HEALTH INFORMATION TO PROVIDENCE CLINICS**

I hereby authorize \_\_\_\_\_ to release medical information regarding my care and treatment to Providence Clinics as provided in this Authorization. I understand that this Authorization applies to all records created in the course of my treatment on the date(s) listed below, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status, including AIDS/HIV.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date(s) of Treatment

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Telephone Number

**Information to be Used and/or Disclosed.**

History/Physical       Emergency Records       X-ray Films       Other (Specify) \_\_\_\_\_  
 Discharge Summary       Pathology Reports       Billing Records      \_\_\_\_\_  
 Operative Reports       Diagnostic Reports       Complete Medical Record      \_\_\_\_\_

(this health information is referred to in the remainder of this Authorization as "Protected Health Information").

**Persons to Whom the Use and/or Disclosure May Be Made.** Specify Providence Clinic: \_\_\_\_\_ ("Clinic").

**Purpose(s) for the Use and/or Disclosure.** The purpose(s) of the use and/or disclosure of my Protected Health Information are as follows:

Continuing Treatment       Payment       Legal Request      Other (Specify) \_\_\_\_\_  
\_\_\_\_\_

In consideration of the release of information by Clinic in accordance with this request, I hereby release Clinic, its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof.

This Authorization is subject to revocation at any time in the form of written notice from me, except to the extent that action has already been taken in reliance thereon. If not previously revoked, this Authorization shall expire one hundred eighty (180) days from the date of my signature. A photocopy or facsimile is valid as the original. To revoke this Authorization, you must send your request in writing to the person or entity listed in the first paragraph of this Authorization.

I understand that neither Clinic nor the entity listed in the first paragraph of this Authorization may condition the provision of treatment, payment, enrollment in a health plan, or eligibility of benefits on the provision of this Authorization, except that: (1) they may condition the provision of treatment-related research on the provision of an authorization for the use or disclosure of Protected Health Information for such research; and (2) they may condition the provision of health care that is solely for the purpose of creating Protected Health Information for disclosure to a third party on provision of an authorization for the disclosure of the Protected Health Information to such third party.

I understand that any information disclosed pursuant to this Authorization is subject to redisclosure by the recipient and may no longer be protected by law. I understand that I must be provided with a copy of this signed Authorization.

\_\_\_\_\_  
Patient or Legally Authorized Representative Signature

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
If Applicable, Relationship to Patient

\_\_\_\_\_  
Witness Signature