ExpertCare
management services
Restoring Lives, Renewing Spirits

# Authorization to Disclose Protected Health Information

| **Consumer's Name** | | | **MRN #** |
|---|---|---|---|
| **Street Address** | | | **Consumer's Date of Birth**<br>/ / |
| **City** | **State** | **ZIP** | **Phone**<br>( ) - |

I authorize ExpertCare to disclose the above-mentioned individual's health information as described below. (Identify type and amount of information, including dates where appropriate.)

_____

_____

_____

This information may be disclosed to and used by the following person or organization:

_____

Name of Person/Organization authorized to receive the protected health information.

_____

Street Address

_____

City, State, ZIP

( ) - ( ) -

Phone Number Fax Number

This disclosure and use is for the following purpose(s):*

_____

_____

_____

*Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to ExpertCare. I also understand that any uses or disclosures already made with my permission cannot be taken back.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

_____

Date, Event or Condition

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization.

| **Legal Representative's Name (if applicable)** | **Legal Representative's Relationship to the Individual (**A letter of authority may be requested) |
|---|---|
| **Signature of Individual or Legal Representative** | Date<br>/ / |
| **Signature of Witness** | Date<br>/ / |