

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

The Memory and Wellness Center is authorized to disclose health information about me to the individuals designated below. You should consider listing your spouse, partner, adult children, and/or any other family member or friend who may be able to assist with your treatment planning.

I hereby authorize FAU to (check all that apply):

use or disclose my protected health information as indicated below **TO:**

obtain my protected health information **FROM:**

- 1. Name:** _____ **Phone:** _____ **Relationship:** _____
E-mail/Fax/Address: _____ **Initial:** _____ **Date:** _____
- 2. Name:** _____ **Phone:** _____ **Relationship:** _____
E-mail/Fax/Address: _____ **Initial:** _____ **Date:** _____
- 3. Name:** _____ **Phone:** _____ **Relationship:** _____
E-mail/Fax/Address: _____ **Initial:** _____ **Date:** _____
- 4. Name:** _____ **Phone:** _____ **Relationship:** _____
E-mail/Fax/Address: _____ **Initial:** _____ **Date:** _____

Information to be released, used, and/or disclosed: (please check all that apply)

Neuroimaging Reports: _____ Latest Lab Reports: _____
Neuropsychological Reports: _____ All Information & Records _____
Latest History and Physical Exam: _____ Other (please specify): _____
Latest Progress Note(s): _____

I understand that this health information may include sensitive information. By initialing below, I am specifically authorizing the release of information relating to:

- _____ **INITIAL HERE** HIV/AIDS and sexually transmitted disease information
- _____ **INITIAL HERE** alcohol and substance abuse information
- _____ **INITIAL HERE** mental health information (**NOT** including psychotherapy notes)

NOTE: If you are requesting the release of Psychotherapy Notes, a separate Authorization is required.

I have read and understand the following statements of my rights:

- This authorization will remain in effect for one (1) year or until I revoke it in writing. However, the revocation will not have any effect on any actions taken before its receipt and processing.
- I may see and copy the information described on this form, if requested.
- I am not required to sign this form to receive my health care benefits and my refusal to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the Information Receiver for my treatment, the operation of and payment to the Information Receiver.
- I received the Notice of Privacy Practices and had the opportunity to ask questions about it, as well as the use and disclosure of my health information before signing. The Notice is subject to change at any time.
- I understand that information released pursuant to this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.
- I am aware that the charge for copying records is \$1.00 per page for the first twenty-five (25) pages and \$0.25 for each additional page thereafter. Please allow up to five (5) business days for copies to be made. Fees are waived when health information is released directly to a health care provider for treatment purposes.
- A copy of this authorization is as valid as the original and is subject to its terms and conditions.

Execution by Authorizing Individual or their Authorized Representative:

Printed Name of Patient/Legal Representative: _____ Date: _____

Patient/Legal Representative Signature: _____

Verification of identity (For Office Use): ☐ Driver's License/State ID ☐ Personally Known ☐ Other