





\*ROICOR\*



**REASON NEEDED**

Please specify the reason for your request:

- Medical care
- Disability
- At My Request/Personal Reasons
- Legal Reasons
- Insurance
- Other \_\_\_\_\_

I understand that if the person/entity that receives the above protected health information is not a health care provider/health plan covered by federal privacy regulations, the protected health information described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Written revocation must be sent to \_\_\_\_\_  
**(fill in hospital or facility name and address where revocations must be sent)**

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

**EXPIRATION**

This authorization will expire in 60 days unless otherwise specified **(insert date or specific event)** \_\_\_\_\_.

I hereby authorize the use or disclosure of my protected health information as described above. I authorize the hospital to release the protected health information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, Acquired Immune Deficiency Syndrome (AIDS), and/or test for antibodies to the AIDS virus (HIV).

\_\_\_\_\_  
 Patient/ Legal Representative\* Date

\*Reason Patient is unable to sign \_\_\_\_\_

\*Describe scope of authority to act for patient \_\_\_\_\_

Provide guardianship, executor of estate, power of attorney papers

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

**Retain original copy in Medical Records. Copy to patient or legal representative.**