MedNOW Clinics, Inc.

Authorization to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____
Previous Name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information is maintained by the above-named practice.
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s): _____

I specifically authorize disclosure of the following conditions (check all that apply):

☐ Drug Abuse ☐ Alcohol Abuse ☐ HIV/AIDS ☐ Psychological or Psychiatric Conditions, including Psychotherapy notes.

Institution to release information:

Name (or title) and organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

You may release this health information to:

Name (or title) and organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Other (specify): _____

This authorization ends*: ☐ On (Date): _____
☐ When the following event occurs: _____
If no end date is provided, this authorization will expire one year from the date of signing

II. My Rights

I understand that I do not have to sign this authorization to receive health care benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an authorization form:

- To take part in a research study.
  or
- To receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization in writing. If I revoke this authorization, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose were to obtain insurance. Two ways to revoke this authorization are:
  1. Fill out a revocation form. The form is available from the office.
     or
  2. Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or Legally Authorized Individual Signature | Date | Time

_____ _____
Printed Name (if signed on behalf of the patient) | Relationship (Parent, Legal Guardian, Personal Representative, etc.)