Authorization for Use and/or Disclosure of Patient Health Information

OPTIMUS MEDICAL GROUP

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_____

Receiving Party

_____

Address

_____

City, State Zip

_____

Telephone # Fax #

Records and Information Pertaining To:

Patients Name_____

Last First Middle

Patients Date of Birth _____ Telephone # _____

Home Address _____

Street City, State Zip

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of the signature unless a different date is specified here _____(date)

Revocation: This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box ☐ specify which type of information is to be disclosed: then sign and date your selection.

	Signature	**Date**
☐ Medical Information	_____	
☐ Psychiatric Information	_____	
☐ HIV/AIDS Test/Treatment	_____	
☐ Other Health Information	_____	
Specify Records to Disclose	_____	

A copy of this authorization is a valid as the original. Patient has a right to a copy of this authorization.

Patient's Signature _____ Date_____