

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize **Georgetown Medical Clinic** to **use** and/or **disclose** certain **protected health information (PHI)** about me to or for the party or parties listed below.

This authorization permits **Georgetown Medical Clinic** to **use** or **disclose** to _____ the following individually identifiable **health information** (specifically

Person or Entity to Receive the information

describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). _____

This authorization will expire on _____.
{Expiration Date or Defined Event}.

When my information is **used** or **disclosed** pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal **HIPAA** Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **Georgetown Medical Clinic** has acted in reliance upon this authorization. My written revocation must be submitted to **Georgetown Medical Clinic's** Privacy Officer **Georgetown Medical Clinic**.

Signed by: _____
Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian