PATIENT AUTHORIZATION
FOR SPECIFIC DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Patient Name:___________________________________

I, __________________________________, hereby authorize LOA to disclose certain protected health information
(Patient / Parent/ Guardian Name)

about (me / my child) with ___________________________________ who is ______________________________ .
(Information Recipient) (Relationship to Patient)

Recipient Address: ____
Street City State Zip

Email address: ____ Phone: (_____)________________

LOA is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc):

____ All Medical Records ____ x-Rays ____ Financial Information ____Specific Information Listed Below:

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I understand that this request does not apply to: (I) certain health information that is not held in LOA's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose:

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I understand that LOA may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to LOA at the address listed below, and if I revoke this authorization, it will have no effect on actions already taken by LOA in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Legal Guardian: ________________________________ Date: _____________

Printed Name of Patient or Legal Guardian: ______________________________

Witness: ____ Date: ______________

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION