AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby authorize my Protected Health Information,
(Signature required below)

I. Described as follows: (Specifically describe the Protected Health Information to be used or disclosed)

_____

_____

_____

II. List the name or other specific identification of the person(s) or class of person(s) who are authorized to make the requested use or disclosure of my Protected Health Information:

_____

_____

_____

III. List the name or other specific identification of the person(s) or class of person(s) you have authorized to use or disclose your Protected Health Information:

_____

_____

IV. List a description of each purpose of the requested use or disclosure, the statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or elects not to, provide a statement of the purpose:

_____

_____

_____

V. This Authorization shall expire on the following date or event that relates to the individual or the purpose of the use or disclosure, (e.g. end of research study):

_____

VI. I understand that I have the right to revoke this Authorization in writing and acknowledge that _____ will use or disclose my Protected Health Information in reliance upon this Authorization.

VII. By signing this Authorization, I acknowledge that I have read and understand this Authorization and I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____ _____

Signature (Patient) Date Signature (Authorized Representative) Date

_____

Description of Authorized Representative's Relationship to Patient

_____ _____

Signature (Witness) (Date)

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