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Garden City, NY 11530
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Dr._____ to use and/or disclose certain protected health information (PHI) about me to **other providers involved or to become involved in my current care.**

This authorization permits Dr. _____ to use and/or disclose any health information about me. The information will be used or disclosed for the following purpose: to contribute to the diagnosis or treatment of my condition.

This authorization will expire on _____.

{expiration date or defined event}.

The practice will never receive any payment or other compensation from a third party in exchange for using or disclosing the PHI.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 the practice has acted in reliance upon this authorization.

_____ _____

Patient's Name Date