

**Authorization Form**

**Patient Name:**

**DOB:**

**Address:**

**Home Phone:**

**Work Phone:**

**Date:**

I, \_\_\_\_\_, give permission to Fairfax Family Practice to use or disclose my personal health information in the manner described below. I have been told that I am under no obligation to sign this authorization form and that Fairfax Family Practice will not condition treatment or payment on my decision to sign this form. I have signed this form voluntarily.

The following is a description of my personal health information that I authorize to be used and/or disclosed.

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The following is a listing of the person(s) and/or organization(s) that I authorize to receive my personal health information as per the limitations listed above. I have been told that is the person(s) and/or organization(s) listed below are not health care providers, a health plan or a health care clearinghouse, that they are not subject to the same Federal privacy rules and that they may disclose my health care information without obtaining my permission.

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The following is a description of the purpose(s) for which my health care information may be used and/or disclosed to the previously mentioned person(s) and/or organizations.

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I understand that I may revoke this authorization at any time by asking to complete a revocation form that Fairfax Family Practice will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form, but if I do sign it, I must be provided a copy of the signed form.

I understand that prior to signing this authorization from, I have the right to inspect and/or copy the health information which will be used or disclose pursuant to this authorization.

I understand that Fairfax Family Practice will (please check one of the following)

not receive any direct or indirect payment in connection with the use or disclosure of my health information.

will receive either direct or indirect payment or remuneration for the use or discloser of my health information in the amount of \$\_\_\_\_\_.

This authorization will expire on: \_\_\_\_\_

I \_\_\_\_\_ (print name) have had an opportunity to read and understand the contents of this authorization form and my signature confirms that this authorization form accurately reflects my wishes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_ (Print Patient Name) is unable to sign because \_\_\_\_\_

\_\_\_\_\_ (Print Name) is the personal representative and has the following relationship to the patient:\_\_\_\_\_. The authority of the personal representative is \_\_\_\_\_.

Personal Representative (Print Name):\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_