Attachment C

AUTHORIZATION
FOR USE AND DISCLOSURE OF
YOUR HEALTH INFORMATION

We, ___________________________________, are prohibited from sharing your
(Name of entity)
personal health information (except as indicated in a Notice you have received or will receive), unless you authorize us to share this information with others. We are asking you to allow us to use or share certain health information about you, as described below. You do not have to sign this Authorization if you do not want to. We will not condition treatment on whether you sign this Authorization (unless you are receiving treatment because you are participating in a research study, or unless the purpose of the treatment is to obtain information specifically for the purpose of sharing it with a third party, such as your family doctor). If you do sign this Authorization, you have the right to change your mind and revoke this Authorization, unless we have relied on this Authorization already. You may revoke this Authorization by submitting your revocation in writing to____.
(Name and title)
We will share only the information needed to accomplish the purposes described below. It is possible that the person or people with whom we share your information under this Authorization might share the information with someone else. If that happens, it is possible that the information might no longer be protected by medical privacy rules. In certain circumstances, other federal state, or local law may prevent us from sharing information about you, even though you have authorized us to share this information. In those circumstances, we will not share health information about you.

The information we will use or share is as follows:

____
____
____
(Description of information to be used or disclosed - must identify the information in a specific and meaningful fashion.)

The people who will give out the health information are the following:

____
(Name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.)

We may share the health information described with the following people:

____
(Name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.)

The reasons why we will share the health information are as follows:

____

____

____

(Description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)

This Authorization will be effective from the date of your signature until

____

(Expiration date of Authorization, or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research depository).

<u>AUTHORIZATION</u>

I, ____, have received a copy of this Authorization. I have read this Authorization and I understand that it explains circumstances in which I permit my health information to be used and shared with others. I authorize the uses and disclosures described in this Authorization.

__________________________ __________________________________

DATE SIGNATURE

<u>AUTHORIZATION BY PARENT OR GUARDIAN (IF A MINOR)</u>

I, ____, am a parent or guardian of the individual named above. I have received a copy of this Authorization. I have read this Authorization and I understand that it explains circumstances in which I permit my child's (or charge's) health information to be used and shared with others. I authorize the uses and disclosures described in this Authorization.

__________________________ __________________________________

DATE SIGNATURE

Notice to users of this form: Contractors and subcontractors of the U.S. Department of Labor should consult their legal counsel in determining whether and how this form may be used in any particular circumstance. The U.S. Department of Labor makes no representations as to the legal sufficiency of this form with respect to any given use or disclosure of information. Contractors and subcontractors are responsible for determining whether they are subject to the HIPAA Privacy Rule and administrative data standards of 45 C.F.R. Parts 160-164, and for complying with those regulations, if applicable.