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AUTHORIZATION FOR DR. WOODFIN TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

Previous Name: _____

You may use or disclose the following health care information (check all that apply):

- ☐ All my health information maintained by Dr. Woodfin
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

You may disclose this health information to:
Name (or title) and organization _____

Address: _____ City _____ State ____ Zip _____

Reason(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify) _____
  _____

This authorization ends:

- ☐ On this date: _____
- ☐ When the following event occurs: _____

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However I do have to sign an authorization form:

- To take part in a research study
  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Dr. Woodfin based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. This form is available from the office.
  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name Relationship (parent, legal guardian, etc.)