Between the Bridges Healing Center

The leading-edge of the new preventive medicine

I: _____ hereby authorize use or disclosure of protected health information about me as described below.

☐ The following facility is authorized to share or disclose information about me:

Name of facility: _____ Fax #: _____

☐ The following facility may receive disclosure of protected health information about me:

Name of facility: _____ Fax #: _____

- The specific information that should be disclosed is

☐ All information

☐ All Progress notes

☐ Lab reports

☐ X-ray/MRI/CT

☐ Immunization records

☐ Other _____

☐ For the time period: ____/____/____ to: ____/____/____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION * _____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- This authorization expires one year from today's date, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.
- I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. The requestor may be provided with a copy of this authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

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