Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, The Morlock Foundation, Inc.(TMF) may not use or disclose your clinical/health information except as provided in our Notice of Privacy Practices without your authorization. The Morlock Foundation, Inc. maintains your clinical/health information in your client record that includes the clinical/health information The Morlock Foundation, Inc. has generated as well as the information it has received from other treating providers involved in your care. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected clinical/health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to The Morlock Foundation, Inc.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use and disclosure of the following clinical/health information that pertains to _____ (print name): (Please specify the type of information or list multiple numbered types of information.) _____
_____

Use or disclosure is for the following purpose(s): (Please specify the purpose or list multiple numbered purposes for the use or disclosure.) _____

I authorize TMF representatives who are involved in my care, treatment, payment for such services or healthcare business operations to make these disclosures.

I authorize the following persons, programs, or agencies to receive these disclosures of my clinical/health information: (Please specify the person/programs/agencies, or numbered list of persons/programs/agencies information is to be disclosed to.)
_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to The Morlock Foundation, Inc. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my clinical/health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on _____.
(insert date or event)

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain or receive services from TMF will not depend in any way on whether I sign this authorization form or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature _____ Date _____

Print Name _____ Relationship to Service Recipient _____

REVOCATION SECTION I hereby revoke this authorization.

Signature _____ Date _____
If completing and signing Authorization Form on behalf of client, please complete the sections below.

PERSONAL REPRESENTATIVE or Authorized Third Party Completing on Behalf of the Individual (as applicable)
Name _____
Address _____
Telephone _____
Description of Personal Representative's Authority to Act for the Individual: _____
_____

Choose one of the following if Personal Representative is completing on behalf of the Individual: (please check one)
__ Documentation supporting Personal Representative's authority previously submitted and on file with TMF
__ Documentation supporting Personal Representative's authority enclosed.