HUMAN DYNAMICS & DIAGNOSTICS

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name_____ Date of Birth____/____/____ Phone_____

Address_____ City_____ State_____ Zip_____

Name of legally authorized representative_____ Relationship_____

SCOPE & PURPOSE FOR SHARING INFORMATION: I understand protected health information is information that identifies me. The purpose of this authorization is to allow Human Dynamics and Diagnostics to receive or share my protected health information as set forth below, for reasons in addition to those already permitted by law.

Persons/Organizations authorized to release or receive my information

Name, Address, Phone, Fax	Relationship	Purpose

Information to be shared (Check one or more boxes below.)

☐Entire Medical Record (includes all records except Psychotherapy Notes) ☐ Treatment Plans and Reviews
☐Comprehensive Diagnostic Assessment ☐ Progress Reports ☐History and Physical ☐ Laboratory Report(s)
☐Other:_____

Dates of Service ☐All dates of service ☐ Specific date or service_____

EXPIRATION AND REVOCATION:

This release will expire: ☐12 months from date of signature ☐Other date or event_____
I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

ACKNOWLEDGEMENTS: I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

SIGNATURE: This document must be signed by the individual or the individual's legal representative.

Signature of Patient or Legal Representative	Printed Name	Date

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