

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

**Information to be Used or Disclosed**

The information covered by this authorization includes:

- |   |   |
|---|---|
| <input type="checkbox"/> Medical Records                        | <input type="checkbox"/> Billing Records      |
| <input type="checkbox"/> Diagnostic Tests including HIV Testing | <input type="checkbox"/> Consultative Reports |
| <input type="checkbox"/> Hospital Records                       | <input type="checkbox"/> Other _____          |

**Persons Authorized to Use or Disclose information**

Information listed above will be used or disclosed by:

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Name of person or organization

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Name of person or organization

**Persons to Whom Information May Be Disclosed**

Information described above may be disclosed to:

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Name of person or organization

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Name of person or organization

**Expiration Date of Authorization**

This authorization is effective through \_\_\_\_/\_\_\_\_/\_\_\_\_ unless revoked or terminated by the patient or the patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Oaks Medical Center. You should contact Marilyn Scheffe, Clinic Administrator to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Signature**

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Name of patient (Print or type)

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Signature of Patient

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Date

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Signature of Patient Representative

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Relationship of Patient Representative to Patient