I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Check One of the Following:

- ❑ I understand that the provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- ❑ I understand that the health care provided by the Provider is solely for the purposes of creating protected health information for (INSERT THIRD PARTY)_____ and that my authorization is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide health care services to me.
- ❑ I understand that the treatment being provided for the provider is related to research and that my authorization of disclosures for research related purposes is a condition of this treatment. I understand that if I do not sign this authorization, then the Provider will not provide research related treatment to me.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Copy To File
Copy to Patient