HIPAA Authorization Form

I _____, hereby authorize the use or disclosure of my protected health information as described below:

1. **Authorized Persons To Use and Disclose Protected Health Information**. St. Jude's Wellness is authorized to disclose the following protected health information to _____ of _____, _____ _____. .
2. **Description of Information To Be Disclosed.** The health information that may be disclosed is: Medical records Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment Mental health records All treatment records Other: Any other information relevant to the treatment of patient. All past, present, and future periods of health care information may be shared. .
3. **Purpose of the Use or Disclosure.** The purpose of this use or disclosure is _____
4. **Validity of Authorization Form**. This Authorization Form is valid beginning on _____ and expires on _____
5. **Acknowledgment**. I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations. I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions

By: _____ **Date:** _____

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