

**Authorization of Use and Disclosure  
 of Protected Health Information**

<p><b>Information will be released from</b>  <input type="checkbox"/> <b>Long Valley Health Center to:</b></p> <hr/> <p>Name of person/organization</p> <hr/> <p>Address</p> <hr/> <p>City/State/Zipcode</p> <hr/> <p>Phone_____</p> <hr/> <p>FAX</p>	<p><b>Information will be released to:</b>  <input type="checkbox"/> <b>Long Valley Health Center from:</b></p> <hr/> <p>Name of person/organization</p> <hr/> <p>Address</p> <hr/> <p>City/State/Zipcode</p> <hr/> <p>Phone_____</p> <hr/> <p>FAX</p>
<p><b>Information to be released:</b></p> <hr/> <hr/>	<p><b>Purpose of Disclosure:</b></p> <hr/> <hr/>

**Expiration Date of Authorization:**

This authorization is effective through \_\_\_\_/\_\_\_\_/\_\_\_\_ unless revoked/terminated earlier by the patient and/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 Long Valley Health Center. You should contact the Privacy Officer to terminate this authorization.

**Potential for Re-disclosure:**

Information that is disclosed under this authorization may be disclosed again by the person/organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Long Valley Health Center releases it.

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

(Type or Print)

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Signature of Patient Representative

DATE: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_