



MIDWEST HYPERBARIC INSTITUTE P.C.

Authorization for Use or Disclosure of Protected Health Information

Date of Request: _____ Date Request Expires: _____

I authorize the use/disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use/disclose information:
VFW Post 5917 / TBI Committee Bolingbrook _____

2. Person(s) or class of persons authorized to receive the information:
VFW Post 5917 / TBI Committee Bolingbrook _____

3. Description of information that may be used/disclosed:
All medical notes and findings related to Hyperbaric Oxygen Therapy treatments.

4. The information will be used/disclosed for the following purposes: (Note: this item is not required if the disclosure is requested by the recipient).

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal Privacy Regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization in writing at any time by _____, except to the extent that action has been taken in reliance to this authorization.

This authorization expires _____.

Signature of Recipient or Representative

Date

Recipient's Name

Name of Personal Representative (if applicable)

Relationship to Recipient

(A copy of this signed form will be provided to the recipient)