



Medical Information Release Form

Authorization for Use or Disclosure of Protected Health Information

I, _____ hereby authorize the **City of Mesquite** to (check those that apply):

Use the following protected health information, and/or

Disclose the following protected health information to: _____
Name of entity to receive information

Specifically describe the information to be used or disclosed:

This protected health information is being used or disclosed for the following specific purpose(s):

This authorization shall be in force and in effect until _____
Specify date or event that relates to the patient or the purpose of the use or disclosure

at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

_____ at _____
Name of privacy contact **Office address or e-mail address**

I understand that a revocation is not effective to the extent that the **City of Mesquite** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The City of Mesquite will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the 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.

Signature of individual

Date

Printed name of individual