

**PATIENT AUTHORIZATION TO DISCLOSE PROTECTED  
HEALTH INFORMATION TO LAW ENFORCEMENT AGENCY**

I authorize \_\_\_\_\_ [insert provider]  
to disclose protected health information ("PHI") from the records of:

Patient name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone number: \_\_\_\_\_

I authorize PHI from \_\_\_\_\_ [date] to \_\_\_\_\_ [date] to be disclosed to  
\_\_\_\_\_  
[insert name, address, and phone number of law enforcement agency].

**Specific description of the information to be disclosed:**

**Specific description of the purposes of the disclosure:**

**I authorize the provider to disclose information related to the following types of care  
(check all that apply):**

- \_\_\_\_\_ AIDS/HIV and other Communicable Diseases
- \_\_\_\_\_ Behavioral Health Care/Psychiatric Care/Mental Health Information
- \_\_\_\_\_ Alcohol and/or Drug Abuse Treatment
- \_\_\_\_\_ Genetic Testing Information

I understand that the provider will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, unless the provider has already relied on my authorization to disclose health information to the law enforcement agency named above. To revoke my authorization, I must submit a written request to \_\_\_\_\_  
[insert name, phone number and address of contact at provider].

Unless I revoke this authorization earlier, it will expire on the following date, event, or condition:  
\_\_\_\_\_.

I understand that, if this information is disclosed to the law enforcement agency, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by that agency. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and agents from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Patient or Description of Authority

**For Hospital Personnel to Document Verification of Officer's Identity, check one of the following to demonstrate identification:**

- \_\_\_\_\_ Badge number and name of department or agency on badge:  
\_\_\_\_\_
- \_\_\_\_\_ Business card (keep copy and attach to this form)
- \_\_\_\_\_ Written request on letterhead (keep copy and attach to this form)
- \_\_\_\_\_ Other proof of status (explain; keep copy and attach to this form if in writing):  
\_\_\_\_\_