

## HIPAA Authorization to Use or Disclose Protected Health Information

I, \_\_\_\_\_ authorize WPI to use or disclose the following  
(name of individual)

information (describe information to be used or disclosed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

to: \_\_\_\_\_  
(name(s) of recipient(s) of information)

for the following purpose(s): \_\_\_\_\_

\_\_\_\_\_

(describe the purpose(s) of the use or disclosure or mark the box below)

This authorization shall expire no later than \_\_\_\_\_.  
(expiration date or event)

I understand that I may revoke this Authorization in writing at any time, except to the extent that WPI has taken action, by sending a written revocation to the HIPAA Contact Person or the HIPAA Privacy Officer.

I understand that if I do not sign this Authorization, WPI may not deny me treatment, payment, enrollment, or eligibility for benefits.

I understand that the information disclosed pursuant to this Authorization to the recipient may be subject to re-disclosure and no longer protected by the federal standards for privacy of individually identifiable health information.

\_\_\_\_\_  
(signature of individual)

\_\_\_\_\_  
(signature of WPI HIPAA representative)

\_\_\_\_\_  
(print name of individual)

\_\_\_\_\_  
(print name of WPI HIPAA representative)

\_\_\_\_\_  
(date of signature)

\_\_\_\_\_  
(date of signature)