AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize this practice to release protected healthcare information of the patient named above to:

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Expirations or termination of authorization: This authorization will automatically renew one year from the date of your signature below, unless you specify an earlier termination. You have the right to terminate this authorization at any time by notifying our privacy manager in writing. _____

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Patient Signature: _____ Date Signed: _____