Authorization to Disclose Personal Health Information

Patient Name:____

Date of Birth:____

Names of Person Eligible to Receive Information on my Behalf:

_________________________ Relationship________________

_________________________ Relationship________________

_________________________ Relationship________________

_________________________ Relationship________________

COMPLETE ONLY IF LIMITED INFORMATION:

___ Information about Insurance only

___Information about Services Rendered only

___Information about Account Balance/Bills only

Check on box indicating how long authorization is valid for:

___ Disclose my personal health information indefinitely

___ Disclose my person health information for specified period only
Beginning (mm/dd/yy) _____________ and ending
(mm/dd/yy)_____________.

Signature________________________________ **Date**________________