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_____