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Authorization for Disclosure of Health Information

Date:_____

Patient:_____ DOB:_____

I _____, have been informed of all HIPAA regulations and rights to protect my privacy. Being fully informed, I authorize the following people to have access to all my medical information in any and all forms of communications.

Authorized Person	*DOB*	*Relationship to Patient*
1.		
2.		
3.		

Detailed messages may also be left on message machines at the following numbers:

_____ _____

I understand this authorization will remain in effect until revoked in writing by myself or the person I select to have my power of attorney.

_____ _____

Patient Signature ***Date***