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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name \_\_\_\_\_  
Patient Address \_\_\_\_\_  
Patient Phone Number \_\_\_\_\_

I authorize the disclosure of my personal health information to the person/entities as described below. I understand this authorization is voluntary and can be revoked at any time in writing, addressed to the contact information listed above.

You have the right to determine an expiration date for this authorization. If no date is listed this authorization will be in effect indefinitely, or until revoked. Expiration date \_\_\_\_\_

I authorize disclosure to the following people/entities:

1. Name \_\_\_\_\_  
Address \_\_\_\_\_
2. Name \_\_\_\_\_  
Address \_\_\_\_\_

By signing below, I confirm the release of my information to the entities listed, and I attest the information listed is, to the best of my knowledge, current and accurate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative on behalf of the individual signs this authorization, complete the following and attach a copy of legal authority if applicable.

Personal Representative's Name: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_