Disclosure of Personal Health Information Authorization Form

Patient Name:_____

Patient Date of Birth:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Description of patient information to be used or disclosed:

X-rays

Chart Notes

Accounting Information

Health Insurance Information

Personal Information (address, phone number, email address)

The purpose of this use or disclosure is at the request of the patient or patient personal representative.

The following person/facility may receive this patient information:

_____

Patient/Guardian Signature:_____