

PATIENT AUTHORIZATION FORM

(PLEASE LIST ANY DOCTORS AND / OR FAMILY MEMBERS WHO YOU WOULD WANT TO HAVE ACCESS TO YOUR MEDICAL RECORDS)

I hereby authorize you to disclose my PHI (protected health information to the following person(s) or entity(s) :

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

NAME:
ADDRESS:
PHONE NUMBER:

I understand that I may revoke this authorization in writing by contacting your office at the address below, attention Privacy Officer.

Patient

Name: _____ Signature: _____

Relationship to patient: _____ Date: _____