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Standard Authorization of Use and Disclosure of Protected Health Information

Persons to Whom Information May Be Disclosed

1. _____ _____
   Name Relationship
2. _____ _____
   Name Relationship
3. _____ _____
   Name Relationship

(My medical history, laboratory, reports, x-rays, and any other material regarding medical consultation and treatment I received).

_____ _____
Print Patient Name / Guarantor Date

_____ _____
Patient Signature / Guarantor Relationship

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization, please see office staff.
This authorization has been Terminate or Revoke Authorization

On _____/ _____/_____

Patient Signature _____

Witness (office staff) _____