Authorization Form

For the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

- ☐ **This authorization will expire upon my request.**
- ☐ **Or by this date _____**

Persons authorized to receive the information:

Name: _____ Relationship to patient: _____

DOB: _____ Phone number: _____

Name: _____ Relationship to patient: _____

DOB: _____ Phone number: _____

Name: _____ Relationship to patient: _____

DOB: _____ Phone number: _____

Name: _____ Relationship to patient: _____

DOB: _____ Phone number: _____

The information will be used/disclosed for the following purposes:

- ☐ Insurance
- ☐ Scheduling/moving/confirming appointments
- ☐ Billing questions

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that the office will not condition treatment, payment, or enrollment in a health plan based on this authorization. I understand that I may revoke this authorization at any time by notifying the office in writing.

Signature: _____ Date: _____

Printed Name: _____