**Authorization to Use or Disclose Health Care Information**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_

Previous name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My authorization, dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclose information to:**

Name (or title) and organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_

**I understand that this request does not apply to any uses or disclosures:**

• Before the practice/health care facility gets this authorization, or

• Allowed or required by law.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship

 (parent, legal guardian, personal representative)