HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name		
I hereby authorize		to use or disclose my
	(Disc)	closer)
protected health informa	ntion related to	
		(Type of Information)
to		for the following purpose:
	(Recipient)	
• I understand that this authorization		copy the protected health information described by
receives this authorized be effective as to where other act	horization receives a the disclosure of rec ion has been taken my health care and th	authorization may be revoked, when the office that a written revocation, although that revocation will not ecords whose release I have previously authorized, or in reliance on an authorization I have signed. I he payment for my health care will not be affected if
	losure by the recipie	or disclosed, pursuant to this authorization, could be ent and, if so, may not be subject to federal or state
Date	Si	Signature of Individual or Representative
	Authority	y or Relationship to Individual, if Representative
EXPIRATION DATE:	This authorization w	vill expire on
If no date or event is sta authorization.	ted, the expiration da	ate will be six years from the date of this

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.