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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We will normally discuss your healthcare matters only with you. If you would like to authorize us to speak with others concerning your healthcare, Please write their full names and their relationship to you in the space provided. This includes spouses, parents, etc. if you do not wish anyone else to have access to this information please write "NONE".

*****This consent has NO expiration date unless indicated otherwise in the " Note" area**

Name of Person/Organization	_Relationship to Patient_	_Notes_
Name of Person/Organization	_Relationship to Patient_	_Notes_
Name of Person/Organization	_Relationship to Patient_	_Notes_

Signature

Signature of Patient | _Print Name of Patient_ | _Date_

Signature of Patient Representative | _Relationship to Patient_

FILE: hipaa

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