

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I have read the authorization for use and disclosure of protected health information. I understand that I have the right to inspect and/or obtain a copy of the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights. Or refuse to sign this authorization.

Name of person or persons we may speak to regarding your health:

May we leave a message regarding an upcoming appointment on your answering machine: _____ Yes _____ No

Patient Signature: _____ Date: _____

Signature of Legal Representative (if other than Patient):

_____ Relationship to Patient: _____

Witness: _____ Date: _____