Authorization to release PHI (Personal Health Information)

I hereby authorize _____ to release my PHI to:

(EXCLUDES PHYSICIANS & ATTORNEYS)

_____

Name of person that information may be released to:
(i.e. spouse, parent, guardian, sibling, etc.)

_____

Address

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Type of information that may be released:
(financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to

There is potential for re-disclosure once this information is disclosed. cannot control what the other entity does with your PHI (Personal Health Information).