Authorization to Release Information:

(If you wish us to be able to talk/discuss your information with your spouse or parents we MUST have their names filled in below)

Purpose: This form is used to obtain authorization to release your personal health information to another person other than yourself under the Privacy Act.

I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

1)_____ 2)_____

Please Print Name Relationship Please Print Name Relationship

3)_____ 4)_____

Please Print Name Relationship Please Print Name Relationship

_____

Print and Sign Date

_____

If Minor------- Relationship to patient Date