AUTHORIZATION TO RELEASE HEALTH INFORMATION

We must disclose your health information to you, as described in the Patient Rights section of the Privacy Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Please provide us with whom you would like us to disclose your information to:

Patients name:_____

Who	Address	Phone #	Relationship

Patient/Guardian Signature:_____