



Patient Health Information- Release Authorization

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want someone other than yourself to pick up documents, x-rays or other items on your behalf.

Please list the names of any individuals that you would like to access or retrieve personal health information, documents, or other items on your behalf:

- | | |
|----------|-----------------|
| 1. _____ | Relation: _____ |
| 2. _____ | Relation: _____ |
| 3. _____ | Relation: _____ |
| 4. _____ | Relation: _____ |

I decline to have anyone pick-up patient information on my behalf.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. Any other use of this information without my written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

Signature of Patient or Legal Representative

Date

Relationship to Patient Witness

Date

POC Representative/ Witness Date

Date