Authorization Request Form
For Use and Disclosure of Patient Health Information

In completing this form, you are authorizing the use and disclosure of your Protected Health Information.

Requested Authorization (please provide specific details and dates):

_____

_____

Information may be released to: (please specify name of person)

□ **Spouse:** _____

□ **Parent:** □ **Mother** □ **Father** □ **Both:** _____

□ **Child(ren):** _____

□ **Attorney:** _____

□ **Physician (please specify):** _____

□ **Other (please specify):** _____

Patient Name (Please print): _____
Patient Date of Birth: _____

Signature of Patient or
Authorized Representative: _____

Relationship (if other than patient signing): _____

Date: _____

FOR OFFICE USE ONLY

Accepts [ ] Denies [ ]

Reason: _____

Privacy Officer Signature: _____

Date: _____

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