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Patient Disclosure Authorization Form

Patient Name: _____ Date of Birth: _____

I authorize disclosure of my protected health information to the individual(s) named below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

Description of information to be released: (please check all that apply)

- ◆ Appointment Times
- ◆ Medical Records Release
- ◆ Billing Information
- ◆ Other (specify): _____

This authorization provides that:

- ◆ I may revoke this authorization at any time, provided that my request is made in writing to Rehab Connection.
- ◆ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA rules and regulations.
- ◆ I have a right to access my protected health information that will be used or disclosed.
- ◆ I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient (if signed by personal representative): _____