RELEASE OF INFORMATION FORM

I, _____, hereby authorize the use or disclosure of my protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

_____ and _____ have my permission to exchange protected health related information about me.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

_____ All past, present, and future periods of health care information may be shared.

_____ All past, present and future periods of health care information may be shared with the following restrictions:

_____

_____

3. PURPOSE OF THE USE OF DISCLOSURE

The purpose of this use and disclosure is _____

_____

4. VALIDITY OF AUTHORIZATION FORM

The Authorization Form is valid beginning on _____

and expires on _____.

5. ACKNOWLEDGMENT

I have the right to change or revoke this Authorization at any time. I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions.

_____

Signature Date