# RELEASE OF INFORMATION FORM

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

# AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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

# 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:

# PURPOSE OF THE USE OF DISCLOSURE

The purpose of this use and disclosure is

# VALIDITY OF AUTHORIZATION FORM

The Authorization Form is valid beginning on

and expires on .

# 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