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Disclosure Request Form

I understand that my health information is private and that use of my health information must be consistent with the previously signed Notice of Privacy Practices. I further understand that certain disclosures of my health information may only be provided by my written consent. I therefore make the following request, and understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, ____ DOB:______________________
(Printed name of patient) *(Date of birth)*

request or authorize: ____
(Name of person or agency releasing infromation)

to disclose to: ____
(Name of person or agency recieving information)

____
(Address)

the following information:____
(Nature of disclosure)

for the purpose of: ____
(Need for disclosure)

This consent expires automatically upon the following: ______________________________
(Date, event or condition)

Patient Signature: ______________________________ **Date:**______________________