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PATIENT DISCLOSURE FORM

Patient Authorization

For The Use and Disclosure of Protected Health Information

1. I, _____ hereby authorize Dr. Wendy Pollock to use and/or disclose the following specific protected health information _____.
2. I understand that this authorization is valid until _____.
3. I understand that the purpose or use of the disclosure I am granting is for the release of medical records.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization _____.
6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

Name of Individual (Printed) _____ Date of Birth _____

Signature of Individual or Parent/Guardian _____ Date _____