Wayne Memorial Community Health Centers

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

I hereby authorize the use of disclosure of the above – named individual's health information as described below.

Person / Organization to **provide / receive (circle one)** information:

Persons/Organization to provide information:	Persons/Organization to receive information:
_____	_____
_____	_____
_____	_____
_____	_____
Phone: _____	Fax: _____

Specific description of information to be disclosed (include dates): _____

_____

_____

Purpose for disclosing information: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that if the organization / individual authorized to receive the information is not a health plan or health care provider: the released information may no longer be protected by federal privacy regulations.

Unless otherwise revoked, this authorization will expire 60 days from the date of signature.

I understand that my health care and the payment of my health care will not be affected if I do not authorize this disclosure. I understand that I will be given a copy of this authorization form, after signing.

_____ _____

Signature of Patient / Legal Guardian Date

If signed by legal representative, relationship to patient _____

_____ _____

Signature of Witness Date