AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PATIENT INFORMATION

Patient Name:_____

Patient's Date of Birth_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I authorize the following person(s) may receive this patient information:

_____

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Signature of Patient/Guardian_____**Date**_____