Family Doctors of Boulder City

Patient Disclosure Preferences

Patient Name: _____

Date of Birth: _____

Social Security: _____

Telephone: _____

Authorization for the release of protected Health Information

You are identifying the following individual(s) as the recipients of your protected health information.

	NAME	PHONE #
1.	_____	_____
2.	_____	_____
3.	_____	_____

I understand that I may revoke this authorization at any time by giving written notice. Revocation will not affect any action taken in reliance on this authorization before I submitted written notice of revocation.

I, _____, attest that the above information is correct and have had full opportunity to read and consider the contents of this authorization. I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature_____**Date**_____

If this authorization is signed by a personal representative on the behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____