Authorization to Allow Disclosure of PHI

Date: ____/______/_______

Name:________________________________

Date of Birth:____/______/_______

I,______________________________, authorize the following individual(s) to receive any and all information regarding my medical care. This includes allowing them to pick up lab information, prescriptions, other referral information from a Huntington Health Physicians office and to make and receive phone calls regarding my health and or the billing related information to the services provided to me by Huntington Health Physicians. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship	Telephone number
1	____________________	__/__/__	_________________	___________________________
2	____________________	__/__/__	_________________	___________________________
3	____________________	__/__/__	_________________	___________________________

Signature of Patient __________________________________ Date ____/_____/_______

If patient is unable to properly sign, patient will sign by marking an "X". A witness is required when signed by marking an "X". Witness must not be an individual named above.

Name of Witness__________________________________

Signature of Witness____ Date ____/_____/_______

For HHP use only:
Signature or ID number of HHP employee that verified identity of patient:_____________________

Information entered into the system on ______/_______/________ by_______________
DATE INITIALS