Authorization for Disclosure of Protected Health Information

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client DOB: \_\_\_\_\_\_\_\_\_

I hereby authorize Dr. Herzig to share my protected health information, both in writing and verbally, with the following individual or organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that by signing this authorization Dr. Herzig can both disclose information about me to the individual or organization listed, as well as be permitted to be the recipient of information from the listed individual or organization.

You may cancel this authorization at any time, and you may request and receive relevant HIPAA guidelines from Dr. Herzig at any time. Please be sure to make Dr. Herzig aware of any privacy concerns. You can and should advocate for your rights as a health care consumer. If you wish for this authorization to expire at a certain time or upon a certain event, please note that here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_

If signed by an individual other than the patient, please print your name here \_\_\_\_\_\_\_\_\_\_\_\_\_\_ and write your relationship to the patient here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Thank you.