I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Legal Name: _____ Relationship: _____

Contact information: _____
Address City State Zip

_____
Home Phone Cell Phone Other Phone

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, x-rays, and billing, for all conditions) **OR**
- B. Disclose my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - Please specify: _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- An electronic record or access through an online portal
- Hard copy

This authorization shall be effective until (Check one):

- All past, present, and future periods, OR
- Date or event: _____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of Birth

_____ _____
Signature of the Individual Giving this Authorization Date