CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, give my permission to disclose my health information to the following people listed below. I have the right to change, update or revoke this information at any time.

This consent expires: ____/____/____.

NAME OF PERSON(S):	INFORMATION TO BE DISCLOSED
Name _____	Medical, Billing, Appointment or All
Name _____	Medical, Billing, Appointment or All
Name _____	Medical, Billing, Appointment or All
Name _____	Medical, Billing, Appointment or All

- I understand that the information disclosed as directed above may be re-disclosed to additional parties and is no longer protected for reasons beyond our control.
- You have a right to receive a copy of this consent if requested.
- Completion of this consent is not a condition for treatment.

Listed below are numbers that can be used to contact me or leave a message. Messages may include test results as well as appointment and payment information.

PHONE NUMBERS:	OK TO LM	DO NOT LM
Home _____	_____	_____
Work _____	_____	_____
Cell _____	_____	_____

Patient's Printed Name: _____ Birth Date: _____

Patient/Legal Representative Signature:_____

Relationship to Patient: _____ Date:_____