



Authorization for Disclosure of Personal and Protected Health Information

I, _____, hereby authorize _____
to release the following information _____
to _____

For the following purpose _____

Mark the appropriate box:

- I understand that by signing this authorization, I authorize the disclosure of my individually identifiable protected personal /health information as described above for the purposes listed
- I understand that by signing this authorization, I authorize the disclosure of the information of the person of whom I am a legal/authorized representative as described above for the purposes listed.

(Adult / Parent / Legal/ Authorized Representative)

Name _____

Signature _____

Date _____