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Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

Patient: _____
Last Name First Name MI Date of Birth

Address: _____
Street City State Zip Code

Medical Records #: _____

RELEASE OF INFORMATION

I hereby give authorization to release information and/or discuss my medical condition including my protected health information such as psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immuno-deficiency Syndrome (AIDS), or tests for infection with Human Immuno-deficiency virus (HIV) with person(s)/entities listed below:

| | | |
|-----------------------------|--|------------------|
| _____ Person/Entity Name | _____ Relationship to Patient(or other) description | _____ Phone # |
| _____ Person/Entity Name | _____ Relationship to Patient(or other) description | _____ Phone # |
| _____ Person/Entity Name | _____ Relationship to Patient(or other) description | _____ Phone # |

I hereby give permission to the Physicians or Staff to leave a medical or appointment message for me on my answering machine, with anyone that may answer my home phone or with one of the contacts listed above.

This authorization may be revoked at any time upon my written request. A photocopy of this authorization is considered valid.

Patient's Signature

Date Signed