AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider, Houm OB/GYN to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

[Purpose]

I authorize the release of my health information for the following specific purpose :

_____

[Information to be disclosed]

I authorize the release of the following health information.

(check the applicable box below)

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information :

_____

Recipient: I authorize my health care information to be released to the following recipient(s).

Name : Date of Birth (mm-dd-yyyy) : Relationship to Patient :

PATIENT			
SIGNATURE	DATE (mm-dd-yyyy)	NAME OF PATIENT	
* If Individual is unable to sign this Authorization, please complete the information below.			
GUARDIAN			
SIGNATURE	DATE (mm-dd-yyyy)	NAME OF GUARDIAN	RELATIONSHIP TO PATIENT