Huntington Health Physicians

Authorization to Allow Disclosure of PHI

Date: ____/_____/_____

Name:_____

Date of Birth:____/_____/_____

I,_____, authorize the following individual(s) to receive any and all information regarding my medical care. This includes allowing them to pick up lab information, prescriptions, other referral information from a Huntington Health Physicians office and to make and receive phone calls regarding my health and or the billing related information to the services provided to me by Huntington Health Physicians. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship	Telephone number
1	_____	__/__/__	_____	_____
2	_____	__/__/__	_____	_____
3	_____	__/__/__	_____	_____

Signature of Patient _____ Date ____/_____/_____

If patient is unable to properly sign, patient will sign by marking an "X". A witness is required when signed by marking an "X". Witness must not be an individual named above.

Name of Witness_____

Signature of Witness_____ Date ____/_____/_____

For HHP use only:
Signature or ID number of HHP employee that verified identity of patient:_____

Information entered into the system on _____/_____/_____ by_____
DATE INITIALS