Authorization for Release of Information

Name of Patient ______________________________Date of Birth__________________

The office of Dr. Bartoo Martin is authorized to release protected health information about the above named patient to the entities listed below.

Entity to Receive Information: Check each person/entity that you approve to receive information:	**Description of information to be released:**
○ Voice Mail	○ Results of lab tests/ x-rays ○ Financial information ○ Other _________________
○ Spouse Name:_______________________	○ Results of lab tests/ x-rays ○ Financial information ○ Other ___________________
○ Parent Name: _______________________	○ Results of lab tests/ x-rays ○ Financial information ○ Other ____________________
○ Insurance	
○ Other (provide name)	○ Results of lab tests/ x-rays ○ Financial information ○ Other ______________________

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient.**

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Signature of Patient or Personal Representative Date

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Description of Personal Representative's Authority (attach necessary documentation)