AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

SPRUCE STREET INTERNAL MEDICINE is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION. Check each person/entity that you approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED.** Check each that can be given to person/entity on the left in the same section.
VOICE MAIL	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
SPOUSE'S NAME:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
PARENT'S NAME:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)
OTHER NAME AND RELATIONSHIP:	Account Information Appointment Information Medical Information (Rx's, treatment, etc.)

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 this document.

If there is any topic of information not listed above that you do not wish disclosed with the person(s) listed as authorized contacts, please list these items here:

_____

_____

_____

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.

_____Date:_____

Signature of Patient or Personal Representative

_____

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