I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

__ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

__ My complete health record, as above, with the exception of the following information:

(Check as appropriate):

- __ Mental health records
- __ Communicable diseases (including HIV and AIDS)
- __ Alcohol/drug abuse treatment
- __ Other (Please specify)

_____

_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- __ All past, present, and future periods, OR
- __ Date or event:

_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____

Name of the Individual Giving this Authorization

_____ _____

Signature of the Individual Giving this Authorization Date