AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release health care records of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Health care information relating to the following treatment, condition or dates: _____

_____

☐ All health care information

Specify Records to be Disclosed:

_____

_____

_____

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. You have a right to receive a copy of this authorization.

PURPOSE(S) FOR THE USE/DISCLOSURE: At the request of the individual

DURATION: This authorization shall become effective immediately and shall remain in effect until _____or for one year from date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that my health care information may not be further lawfully used or disclosed unless another authorization is signed by me or unless such use or disclosure is specifically required or permitted by law.

Patient Signature: _____ Date Signed: _____

Authorized Agent: Knox Attorney Service, Inc./ Knox Services LLC.

COPIES OF THIS SIGNED AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL.