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:

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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.