

Authorization for the Use and/Or Disclosure of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

Medical Record

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

East End Primary Care PLLC and its employees

3. I authorize the following persons (or class of persons) to receive my protected health information:

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing.

Signature

Date

Name

Name of Guardian (if applicable)

Relationship to Patient