



Authorization for Release of Information

Patient Name: _____

Date of Birth: _____

I authorize Debbie Nesbitt, ARNP to release protected information from my clinical health record to the following person or party:

_____ Initial

Name _____

Address _____

Phone Nbr _____

I authorize the release of protected information from my medical records to Debbie Nesbitt, ARNP from the following person or party:

_____ Initial

Name _____

Address _____

Phone Nbr _____

I have had explained to me and fully understand this Authorization for Release of Information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part and I can rescind it via written request at anytime. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPPA (Health Insurance Portability and Accountability Act) Privacy Rule. I also understand that I have the right to revoke this authorization in writing, at any time and that this authorization will expire 90 days after the date of my signature unless otherwise specified.

This authorization shall be in effect until: _____

Patient Name (Print)

Signature

Date

Legal Guardian (Print)

Signature

Date