



# Release of Information

**Name** Joe Dirt

**Date of Birth** Saturday, July 27, 1991

**Healthcare Provider Name or Person who shall obtain information** Jane Philgood

**Phone Number of Recipient** (775) 123-4567

**What information shall be disclosed (please indicate specific information if selecting "other")**

- All Medical Information
- Drug/Alcohol Abuse Treatment Records
- Congenital Information & Diseases

Or

Or

**From Date of Signature on this Agreement Until:** Tuesday, July 13, 2021

**Method of Disclosure**

- Softcopy document (electronic document or web)
- Hardcopy document

**Purpose of Disclosure** To ensure all my medical information is available to Dr. Philgood

I understand that the information I am disclosing to individuals or organizations above may not be protected by the State or Federal rules governing privacy and security of data.

I hereby understand that I may revoke the authorization I have provided in sharing my health information at anytime upon submitting a notice in writing to the healthcare provider and/or the specified persons indicated above.

I fully understand that in case my information has been shared prior revocation, the knowledge acquired

by the recipients cannot be revoked.

I understand that my failure to sign or the cancellation of this authorization does not avoid from receiving treatment, enrollment, or eligibility for or benefits I am entitled to receive, provided the information herein shall not be required in determining whether I am eligible to receive treatments or benefits or to pay for the services I receive.

**Date**

Monday, July 13, 2020

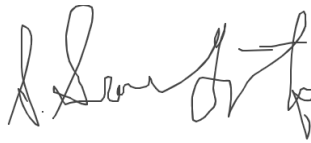
**Resident Signature**



**Staff Witness Full Name**

Sally Sassypants

**Staff Witness Signature**



**Privacy Practices Policy**