Authorization for Disclosure of Protected Health Information

DISCLOSURE AUTHORIZATION

Patient Name:_____ DOB: ___/__/____
Parent/Guardian Name: _____

As the person signing this authorization, I understand that:

- The provision of treatment or payment cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by the recipient may no longer be protected by this authorization.
- The original or copy of the authorization shall be included in the medical record.

I am authorizing Good Beginnings, Inc. (Provider) to disclose my health information to the following organization(s) or person(s) specified below:

Organization(s) or Person(s): _____

Purpose for disclosure: _____

Information to be disclosed: _____

Method of disclosure (Mailed, Emailed, Verbal, etc.): _____

Additional Details as needed: _____

_____ _____

Print Name Date

_____ _____

Signature Relationship to Patient