______________________________________ DOB ______________________________

Address ____

Phone Number ___________________________ Parent Name ______________________________________

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Name ___________________________________ Organization______________________________________

Address ____

For the purpose of: ______________________ **to the extent that action has been** ______________________ **p9TT1 1sc8/8ref1T/TT2**

takn based on this authoriation. I understand that I hae a right to a copy of this authoriation.

I understand that authoriation for the disclosure of this health information is voluntary and I can refuse to sign this authoriation. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authoriation. I understand that any disclosure of information carries with it the potential for redisclosure and once the information is disclosed, it may no longr be protected by federal H confidentiality rules.

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Signature of Patient or Athorized Personal Representatie **Date**

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Personal Representatie's Name (print) and Relationship **Date**

This authoriation reflects the requirements of H