PRIME
SPORTS INSTITUTE

Authorization for Use and Disclosure of Health Information

PATIENT INFORMATION:

Patient Name (Last, First, Middle)	
Current Address (including City, State, Zip)	
Phone #	**Date of Birth** (MM/DD/YYYY)

I hereby authorize written and/or verbal disclosure of my healthcare information as indicated:

RELEASE INFORMATION FROM	**RELEASE INFORMATION TO**
Name	**Name**
Address (including City, State, Zip)	**Address** (including City, State, Zip)
Phone	**Phone**
Fax	**Fax**

INFORMATION TO BE RELEASED *(check all that apply)*:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition: _____

_____

- ❑ Health care information in my medical records for the dates: ____/____/____ to ____/____/____
- ❑ Other (eg., x-rays, bills), specify date(s): _____

This authorization will be valid for 1 year from the date signed, unless you indicate a shorter period below.

_____ through _____

MM/DD/YYYY MM/DD/YYYY

_____ _____

Patient or legally authorized individuals signature *Date* *Time*

_____ _____

Printed name if signed on behalf of the patient *Relationship*

Once health care information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.