



# CRYSTAL LAKE HEALTH CENTER

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[www.crystallakeclinic.com](http://www.crystallakeclinic.com)

## Authorization for Disclosure of Medical Information

I, \_\_\_\_\_ whose date of birth

is \_\_\_\_\_ authorize **Crystal Lake Health Clinic** to release protected

health information to the following person(s):

List individual(s) who authorization is granted to: (please limit access to two individuals)

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Home/Cell Phone

2. Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Home/Cell Phone

Additional Comments/Requests:

\_\_\_\_\_  
\_\_\_\_\_

This release is effective until revoked. I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer at the address above. I understand that revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

X

\_\_\_\_\_  
Signature of Patient or Personal Representative

X

\_\_\_\_\_  
Date