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Authorization to Disclose Protected Health Information

I, _____ (Patient Name), _____ (Date of Birth) authorize Michael D. Leu, D.Ph., N.D. to disclose my protected health information (PHI) to:

	Name	Phone Number	Relationship to Patient
1			
2			
3			
4			

By signing below, I understand and agree that:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Patient or legal representative's signature: _____ Date: _____

Print Name: _____

If a legal representative signed this form, describe the relationship (parent, legal guardian, Power of Attorney, personal representative): _____

This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; three years after the signature date; or the following specific date (Optional): _____