HIPAA Protected Health Information Form

Name:____________________ DOB:________

I____authorize Arizona Liver Health to release and/or discuss protected health information pertaining to my care to the below listed individuals. I realize that if I've listed an emergency contact on my registration paperwork, and I want them to have access to my protected health information, I must list them below. I also understand I may revoke access to the listed individuals at any time. I also understand the withdrawal must be in writing.

Name/ Relationship/ Telephone Number

1. ____
2. ____
3. ____
4. ____

_____ I **do not** authorize my medical records to be released or discussed with anyone.

____ ___________________
Signature of Patient or Legal Representative Date