Jackson Regional Women's Center

Authorization to Release Protected Health Information

I _____ give my authorization to release protected health information to _____ who's relationship to me is _____, if I am unable / unavailable to receive this information concerning my medical record. If there are any other people you would like to authorize, please place their name and relationship on the following lines:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Printed Name (Patient) *Date*

_____

Patients Signature

***I do **NOT** wish to assign anyone other than myself to receive information pertaining to my medical record.*

_____ _____

Patient's Signature *Date*