



## Authorization to Disclose Protected Health Information

I authorize disclosure of my protected health information for purposes of communicating results, findings, and care decisions to my family members and others as indicated below.

I acknowledge that no information regarding my healthcare can be communicated without my permission unless I become incapacitated. If I become incapacitated healthcare providers will communicate to individuals assigned in advanced directives previously designated by me. If no advanced directive has been designated I acknowledge that healthcare providers will communicate to my nearest next of kin.

Please select a unique identifier or password that you will need to give to the individual(s) listed below to help identify those individual(s).

Name	Relationship	Phone	*Unique identifier/ Password
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness to Signature

\_\_\_\_\_  
Date and Time