Betty Chung Grasty M.D., P.A.
Board Certified Internal Medicine

Authorization to Disclose Health Information

PERSONS AUTHORIZED TO RECEIVE INFORMATION

_____ _____
NAME OF PERSON **RELATION**

_____ _____
HOME PHONE **CELL PHONE**

USE AND DISCLOSURE OF INFORMATION

_____ I **authorize** the person listed above to receive **ALL HEALTH INFORMATION** about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Dr. Grasty's office.

_____ I **do not authorize** the following information to be disclosed to any other parties except to me as the patient.

RIGHT TO TERMINATE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Dr. Grasty's office. Please contact the office manager or other authorized representative to terminate this authorization.

POTENTIAL FOR RE-DISCLOSURE

The person to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under federal privacy regulations.

_____
(Print) PATIENT NAME

_____ _____
SIGNATURE OF PATIENT **DATE**

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