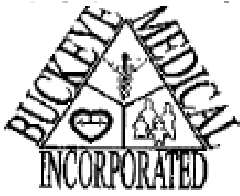

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____________________ Birthdate: __________

By signing this authorization form, you are agreeing to the disclosure of your health information. Buckeye Medical, Inc. will not condition providing treatment to you on your execution of this authorization form.

You have the right to revoke this authorization by requesting to revoke and completing the revocation section of the form below.

I hereby authorize Buckeye Medical, Inc. to make the use or disclosure of my health information as set forth below.

Information to be disclosed:

____
____
____

Recipient (**NAME AND PHONE NUMBER**):

____
____
____

____

This Authorization is: Indefinite Single Use (Please Circle)

Please be aware that any information that is disclosed to a third party pursuant to this authorization may be subject to redisclosure and no longer protected by our policies and applicable law. The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/ or substance abuse, and mental illness.

Date:______ ____________________________ ____________________________

Printed Name — Signature of Individual or Personal Representative

Revocation

(To be completed by patient if patient subsequently wishes to revoke authorization)

I hereby revoke this Authorization.

Signature: ______________________________ Date: ____________________