



Authorization For Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All medical records

Office notes

Inpatient records

Discharge Summary

Procedures and Complications

Consultation reports

History & Physical Records

Outpatient clinic notes

Other: _____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

For my doctor's information For designated persons information

Other: _____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by **ANDREW ALBERT, MD MPH**

Persons to Whom Information May Be Disclosed: Information described above may be disclosed to:

Spouse: _____

Son/Daughter: _____

Friend: _____

Physician: _____

Other/relationship: _____

Date of Authorization

The effective dates of this authorization: _____ - _____

Signature of patient or personal representative

Date

Patient's date of birth

Patient's social security number

Printed name of individual's personal representative (if applicable)

Rationale for serving as personal representative (i.e. parent, guardian)