

**AUTHORIZATION TO RELEASE INFORMATION**

Patient Name :

Social Security # :

I hereby authorize Glenn Tisman, M.D. A Medical Corporation to make use and disclosure of my protected health information. Information about me in my medical records ; financial records as indicated below :

THIS INFORMATION IS TO BE DISCLOSED TO THE FOLLOWING PERSON(S) :

	<u>NAME</u>	<u>RELATIONSHIP</u>
1)	-----	-----
2)	-----	-----
3)	-----	-----
4)	-----	-----
5)	-----	-----
6)	-----	-----
7)	-----	-----
8)	-----	-----

DESCRIPTION OF INFORMATION TO BE DISCLOSED :

**TO BE READ AND SIGNED BY PATIENT :**

I understand the following :

- a) I may invoke the authorization at any time by providing a written notice to the practice.
- b) I may not be able to invoke the authorization if the practice has already taken action utilizing authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- c) the practice will not condition treatment or payment based on my signing this authorization.
- d) No one has pressured me to sign this authorization.
- e) The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
- f) I acknowledge that I have had the opportunity to review this authorization and understand the terms of disclosing my protected health information.

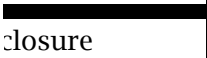
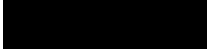
PATIENT SIGNATURE :

DATE :

**FOR OFFICE USE ONLY**

DATE UPON WHICH AUTHORIZATION WILL EXPIRE :

EMPLOYEE INITIALS :



closure  
and/or



HP

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