Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated.

Patient Name Printed:_____

Social Security Number: XXX-XX-_ _ _ _ **Date of Birth**:_____
Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information about me.
Who will provide or disclose information:

NoSweat Fort Wayne
5743 Wilkie Drive, Suite 1
Fort Wayne, IN 46804
Phone: (260) 413-5879

Who will be authorized to receive information (family, friends, others):

Name:_____Relationship:_____Phone: ( ) _____

Name:_____Relationship:_____Phone: ( ) _____

Name:_____Relationship:_____Phone: ( ) _____

Description of the information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

__All records, including every category listed below
__Office notes, labs and x-rays only
__office notes __lab results __x-rays; hospital
__other physicians records
__financial history report (previous 3 years only)
__only disclose the following: _____

Purpose of disclosure: (please check the purpose of the disclosure or check patient request):

__ Patient Request
__Other (please specify): _____

Expirations or termination of authorization: This authorization will expire upon the termination of your physician/patient relationship with NoSweat Fort Wayne, unless you specify an earlier termination. Your have the right to terminate this authorization at any time. Your must notify us in writing, if you decide to terminate the authorization prior to the normal expiration date.
Right to revoke or terminate: You have the right to revoke or terminate this authorization by submitting a written request.
Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient signature _____ **Date** _____
You have the right to receive a copy of signed authorizations upon request.