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)

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