POLARIS FAMILY MEDICINE

PERSONAL/PRIVATE RELEASE OF HEALTH INFORMATION AUTHORIZATION OF HIPAA DISCLOSURE

Patient Name: _____ D.O.B.: _____

I, _____, authorize Polaris Family Medicine and/or their agent(s) to release any and all of my personal/private health information to:

Legal Name	Phone	Relationship
Legal Name	Phone	Relationship
Legal Name	Phone	Relationship

I understand that some information contained in my record may be sensitive in nature. I also understand that any change in this release/request must be made in writing.

Signature Date