AUTHORIZATION TO DISCLOSE HEALTH INFORMATION NOTICE

Federal law says that Janice B. Footlik cannot share your health information without your permission except in certain situations. If you sign this form you are giving Janice B. Footlik permission to share your health information that Janice B. Footlik has with the person you indicate below. This authorization is voluntary.

Right to Revoke If you decide you do not want Janice B. Footlik to share your health information any longer sign the revocation form at the end of this form.

My Name _____ Date of Birth_____

Social Security Number _____

I give Janice B. Footlik permission to share my health information with _____ so that this person can assist me with my health care issues.

Janice B. Footlik may share my health information for one year after the date of this authorization form or until I revoke this authorization.

I want Janice B. Footlik to share this health information (check all that apply):

- ☐ All my information
- ☐ Information regarding prescription drug coverage
- ☐ My health information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
- ☐ My health information regarding treatment for alcohol and or substance abuse
- ☐ My health information regarding behavioral health services or psychiatric care
- ☐ Other

This form must be signed by the patient or parent if the patient is a minor

Signature _____ Relationship to patient _____

Revocation Of Authorization

I no longer want Janice B. Footlik to share my health information with the person or entity indicated above.

My Name_____ Social Security number_____

Signature _____ Date_____