## PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

I authorize the following person(s) to obtain and/or disclose protected health information (PHI) about me.				
Name:		Address:	Phone:	Relation:
and/or	=	dentifiable health in	permits Monterey County Surgi formation about me. I also und	
0	Appointment History a	and Scheduling Appo	intments only	
0	Requesting records on my behalf only			
0	All matters related to			
0	All matters related to	ny patient chart exc	ept:	
0	Only this information:			
This au	uthorization is valid: (Gi	ve dates)		
From :			То:	
-OR-				
0	This authorization is valid until I revoke it in writing			
Patien	t Name:		Date of Birth:	
Signature:		Date:	Date:	