

**Patient Information (please print):** 

## AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information. I understand that this authorization is voluntary.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

ap	pointments	May we discuss medical information or billing information with someone ou wish to have this permission.	
		NAME	RELATIONSHIP
	1		
	2		
	3		
owlede	provide the provid	he phone number:ote data charges may apply per your ce	eminders via Text Message? If yes please ell phone carrier)  Intil a notice of change is provided in writing ice of Privacy Practices. I have had full opportunity
		ontents of the Wilmington Health Notice of Pri	
d and c		re:Date:	