



GROVE INTERNAL MEDICINE

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Name: _____

Date of Birth: _____

Grove Internal Medicine will only disclose the personal health information you want disclosed.

Fill in the name of the person(s) to whom you want **Grove Internal Medicine** to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

What personal health information would you like disclosed:

Expiration of authorization: _____ (date or event).

Signature of Member/Participant, Personal Representative, Parent/Guardian who is authorizing the Release: _____

Date: _____