Authorization for Disclosure of Protected Health Information

I _____, give permission to HealthMotivate Care, to share and discuss protected medical information regarding my care to:

	NAME	RELATIONSHIP	LAST FOUR DIGITS OF THEIR SS# OR THEIR MOTHER'S MAIDEN NAME
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Information to be disclosed (check all that apply)

□ All information

□ Exception(s):_____

This authorization is valid indefinitely unless notified by patient. You may revoke this authorization at any time.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative