



Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient	t Name:	Physician:	
		Date of Birth: Account Number:	
	Disclose health information to:		
	Address:	City, State, ZIP:	
	Phone:		
	Obtain health information from:		
	Address:	City, State, ZIP:	
	Phone:		
Specifi	c description of the health information to be service, etc):	be used/disclosed/obtained (include dates of service, i.e., appointment date,	
-	service, etc.		
type of This he		d for the following purpose (if Authorization requested by the patient put: "At	
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Please send all record requests to your local AllerVie Health location. To find the location nearest you, please visit allerviehealth.com.