## **Limited Patient Authorization for Disclosure of Protected Health Information**

Patient Name (please print)		
Name	Birthdate	SS#
	te <b>Gillette Internal Medicine As</b> ation, about me, to: ( <u>to whom</u> do	
	Ma	Mailed/Date
	Fa	Mailed/Date x it to
	Pic	ck up on
City, State, Zip		Date
person identified above ( <u>what</u> do <b>Date(s) of Ser</b> Progress Notes	Laboratory/Pathology	
History/Physical Medicines Other:	EKG/GXT	ord X-ray
	clude Psychiatric, Alcohol, Drug A	
<ul><li>Continue medical care</li><li>Personal use</li></ul>	are you releasing this informatio Transferri Surgery	ng to another provider/clinic
one year from the time you sign have to submit a new authorizate Date you want this authorization  Right to revoke or terminate – (providing the information has nour Privacy Manager. This can Gillette	authorization – This authorization it (below), unless you specify artion after the expiration date to conto end if earlier than one year:  You have the right to revoke or to already been disclosed) by sube done in-person or by mailing a Internal Medicine Associates.  T.S. Medical Arts Court, Suite I	terminate this authorization arequest to a request to:  , P.C.
Redisclosure – We have no co protected health information. Th this authorization will no longer	Gillette, WY 82716-3372 Attn: Privacy Manager.  Introl over the person(s) you have berefore, your protected health in be protected by the requirements of Gillette Internal Medicine Asserts	e listed to receive your formation disclosed under s of the Privacy Rule and will
Patient signature	Relation/Authority	Today's Date

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