Marshall
Wound Healing Center

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Wound Healing Center

Name of Patient: _____
(Last) (First) (Middle)

Physician's Name: _____ **Patient's Age:** _____

I hereby authorize the Wound Healing Center, its physicians, employees and authorized agents ("WHC") to:

1. Release the following protected health information (specifically identify the information to be released, including whether such information includes written materials, photographs, video recordings and/or audio recordings): _____
_____

2. I authorize such protected health information to be disclosed to (specifically identify the persons who will receive the information): _____
_____

3. I understand that my protected health information will be used as follows (specifically disclose use of information): _____
_____

4. This Authorization shall be effective on the date of execution, as indicated below, and shall continue in effect until _____. Upon the conclusion of the specified time period, this Authorization is automatically revoked and no further use or disclosure of my protected health information is permitted beyond that date.

5. I understand that this Authorization will be subject to the following conditions:

(a) I may refuse to sign this authorization. WHC may not condition treatment upon the signing of this Authorization unless such treatment is research-related or solely for the purpose of creating protected health information for disclosure to a third party.

(b) I may revoke this Authorization at any time, except to the extent the WHC has already taken action in reliance on this Authorization. My revocation of this Authorization must be submitted in writing to WHC at the address indicated above.

(c) I am voluntarily signing this Authorization and will receive a copy of the fully executed form.

(d) I acknowledge that the protected health information authorized to be released pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected under the federal privacy laws.

Signature: _____
(Patient or Legal Guardian)

Relationship to Patient: _____ **Date:** _____

Patient Label: