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: