## UNCONDITIONAL AUTHORIZATION TO USE AND/OR

## DISCLOSE PROTECTED HEALTH INFORMATION

Purpose: This form is used to request an individual's unconditional authorization to use and/or disclose protected health information.

Name:			
Address: (Street)			
(Street)	(City, State)	(Zip)	
Telephone:	Social Security Number	Social Security Number:	
SECTION B: Please read and comp	slate the following:		
Effect of Granting this Authorization:	The protected health information described in s that are not health plans, health care providers		
Persons Authorized to Receive and Us persons) authorized to receive and/or u	e: Name and provide social security number of use the protected health information:	f the person(s) (or class of	
revocation to the office listed below. I	nay revoke this authorization at any time by give understand that revocation of this authorization zation before receipt of my written notice of revocation before receipt of my written notice of revocation before receipt of my written notice of revocation.	n will <i>not</i> affect any	
Telephone: <u>260.492.7451</u>	Fax: <u>260.492.7292</u>		
Address: 10319 Dawson's Co	reek Blvd., Ste. C, Fort Wayne, IN 46825		
SECTION C: SIGNATURE			
	, have had full opportunity to read and cogning this form, I am authorizing the use and/or med in this form.		
Signature:	Date	:	