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## **Authorization to Release Protected Health Information**

Patients may authorize the release of information from their medical/financial records to any designated person(s) they choose. If you would like to give someone permission to access your chart information, please fill out the information below:

**“I authorize NVOMSA to release medical/financial information from my personal records to the following person(s), and I understand that I may revoke this authorization at any time by written request ONLY.”**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_