

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION  
( In Compliance with HIPAA Reg. § 45 CFR 164.508 )**

**TO: ANY Hospital, Clinic or Health Care installation where I may be  
admitted as a patient**

You are hereby authorized in the event that I am physically unable to give permission to have my name, condition and room number disclosed, to place such information on the hospital directory so that when individuals interested in me contact the hospital, such information can be disclosed to them.

This authorization is initiated at my request.

I understand that the information disclosed may be subject to re-disclosure by the individuals who obtain it and that such information would no longer be protected by the federal privacy regulations. ( 45 CFR 164.508(c)(2)(3) )

This Authorization will expire upon my release from your Hospital, Clinic or Health care installation.

**Date:** \_\_\_\_\_

\_\_\_\_\_  
*Signature of Individual*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Printed Name*