

**Quaker Medical Associates
Authorization for Disclosure of Health Information**

This form authorizes _____ to disclose to
_____, the following specific information: _____

This authorization is granted for the following purpose(s): _____

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's or Recipient's privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a healthcare plan, and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

Name of Individual

Signature of Individual

Or, if authorization given by Personal Representative:

Signature of Personal Representative
(e.g., Attorney-in-fact, Guardian)

Description of Authority to act as
Personal Representative

Date Signed ___/___/_____