Chrosniak, Schwartzbauer, & Mehta, M.D., P.A.
18111 Prince Philip Drive #224
Olney, MD 20832

DISCLOSURE TO FAMILY / FRIENDS

_____ **I do not** want Chrosniak, Schwartzbauer, & Mehta, M.D., P.A. (Provider) to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ **I authorize** Provider to disclose any information relating to my care and treatment to the following named individual(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____

_____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice.
- Information used pursuant to this authorization may be subject to review by the recipient and no longer is governed by HIPAA privacy rules.
- I have the right to access my protected health information to be used or disclosed.
- I may receive a copy of this completed and signed authorization form.

_____ _____
Signature Date

_____
Relationship to patient (if signed by a personal representative of patient)