UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ DOB___/___/_____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature:_____ **Date___/___/_____**