THE THOMAS AGENCY

AUTHORIZATION FOR THE RELEASE
OF HEALTH CARE INFORMATION

I, _____
authorize The Thomas Agency to disclose my health care information relating to
_____
_____ to the following individuals or
entities_____
_____ for the following purposes _____
_____
_____.

This authorization [may] [may not] be used for the release of additional information to the same person or entities for the same or related purposes.

This authorization will remain in effect until _____. This authorization will expire within 30 months after it's execution unless you select an earlier date for its termination.

You _____, may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

You, the patient, may revoke this authorization at any time by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation. If you do revoke this authorization, that action could result in the denial of health benefits or other insurance coverage or benefits.

You, the patient, must deliver the revocation of your authorization to us by hand, by certified mail, or by express delivery service.

You are entitled to a copy of this authorization.

_____ _____
Date Signature of Patient/ Guarantor