Will Family Medical Group

Authorization of Disclosure of PHI by **WFMG**

Authorization of Disclosure of Protected Health Information by Will Family Medical Group for use by Another Covered Entity

Information to be Used or Disclosed includes:

____

Information described above will be disclosed by:

Will Family Medical Group **Phone: (760) 360-0333**
42575 Washington Street **Fax: (206) 600-5052**
Palm Desert CA 92211

Information described above may be disclosed to:

____
Name Of Person/Organization

____
Address

____
City/State/Zip Code

____
Phone Number/ Fax Number

This authorization is effective through ____________ unless revoked or terminated by the patient or patient's representative.

You may revoke/terminate this authorization by submitting a written revocation to **Will Family Medical Group**.

Information that is disclosed under this authorization may be re-disclosed if specifically required or permitted by law.

________________________ ________________________________
(Print) Name of patient **(Signature) of Patient or Patient Representative**

Date Of Birth ____________ **Social Security** ________________ **Date** __________