Will Family Medical Group

Authorization of Disclosure of PHI by Another Covered Entity

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

Information to be obtained under this authorization includes:

_____

Persons authorized to use or disclose Information **(Previous Provider)**

_____
Name Of Doctor/Organization

_____
Address

_____
City/State/Zip Code

_____
Phone Number/ Fax Number

Information described above may be disclosed to:

Will Family Medical Group
42575 Washington Street
Palm Desert CA 92211

Phone: (760) 360-0333
Fax: (206) 600-5052

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** _____