



AUTHORIZATION FOR RELEASE OF INFORMATION

As deemed under the HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance Privacy Standard code 164.508(b)(6).

I, _____, the undersigned do hereby authorize:

(Physician, Hospital, Clinic)

(Address)

(City, State, Zip Code)

(Phone number)

(Fax number)

To release information to:

Middle Path Medicine
180 West Le Point St. Suite A
Arroyo Grande, CA 93420
(805) 481-3442
FAX Number: 805-481-3443

Any information which said person/company may request concerning my present illness/injury while I was treated by the person/persons named above.

Date

Patient's Signature