MITCHELL/WHITTAKER/WU DISCLOSURE AUTHORIZATION

I _____ herby authorize the

doctors and staff of the offices of Mitchell, Whittaker & Wu to disclose my protected

health information to _____
(print name/phone number)

For the following purpose:
_____

- I understand that I have the right to revoke this access to my person medical information at anytime. I also understand that should I revoke this access, records that were previously released while authorization was in effect cannot be retrieved.
- I understand that I am granting access to my information however all payments for my health care will be my responsibility.
- I understand that information used or disclosed, with regard to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state laws protecting its confidentiality.

_____ _____
(date) (Signature)

Expiration date: This authorization will expire on _____
If no date is stated, the expiration date will be six years from the date of this authorization.