Patient's Name:_____Date:_____

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED

HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Drs. Wilkes and Warner to use and/or disclose certain protected health information (PHI) about me to or for the parts or parties listed below.

This authorization permits Drs. Wilkes and Warner to use or disclose to (name of insurance)_____the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.) conclusive.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Drs. Wilkes and Warner had acted in reliance upon this authorization. My written revocation must be submitted to Dr. Wilkes and Warner's privacy officer at 3320 Tates Creek Road, Lexington, Kentucky.

If you would like a full copy of the HIPPA disclosure, please see one of our receptionists.

Signed by_____
Signature of Patient or Legal Guardian

_____
Relationship to Patient