THE HIRSH CENTER
for ARTHRITIS and SPORTS MEDICINE

The Hirsh Center Authorization to Disclose Health Information

Patient's Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The Hirsh Center is authorized to make the following disclosure:

☐ Entire Health Record

☐ Other_____

3. This information may be disclosed to and used by my physicians and the following individual(s):

☐ Relatives:

- _____ Relationship: _____
- _____ Relationship: _____
- _____ Relationship: _____
- _____ Relationship: _____

☐ Other:

_____

_____ _____

Patient Signature Date

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