AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Joseph M McCreery MD

I authorize Joseph M. McCreery, MD PLLC to disclose protected health information about:
Name _____, Birth date _____

for the time period beginning_____and ending_____

Information to be Disclosed: *Please check all appropriate boxes*
❒ Summary of Treatment ❒ All records

I understand that the information in my health record may include information relating to behavioral or mental health services and treatment for alcohol or drug abuse or dependency. My health record may also include information about sexually transmitted disease, acquired immuneodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV).
I choose to exclude the more sensitive information: ❒

Person/Organization to receive the information:

NAME OF PERSON/ORGANIZATION	COMPLETE ADDRESS	PHONE/FAX

Purpose: ❒ Transfer of care
❒ Other

This authorization expires on _____ (date) or when the following event occurs: _____. Except when authorizing disclosure to a third party payer, I cannot authorize disclosure for more than ninety (90) days. If I do not provide an expiration date or event, then this authorization will automatically expire within ninety (90) days of then date of authorization.

By signing this page, I acknowledge that I have read and agreed to the terms of this form.

DATE:	SIGNATURE: PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION
WITNESS:	IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF THEIR AUTHORITY.

You may request a current mailing address by leaving a voice mail at 206-550-2092 or by email at jmc@jmcmd.org.
Or you may email the completed and signed form as an attachment to jmc@jmcmd.org .
Please be advised that confidentiality of email messages cannot be guaranteed.

Joseph M McCreery MD