Humboldt General Hospital

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

NAME:_____ DATE:_____

I authorize Humboldt General Hospital Rural Health Clinic and/or the staff at Humboldt General Hospital to discuss my medical and health information with the following individual(s):

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

_____ _____
AUTHORIZED SIGNATURE DATE

I have reviewed the above and agree it is still correct to my knowledge.

_____ _____
AUTHORIZED SIGNATURE DATE

_____ _____
AUTHORIZED SIGNATURE DATE

_____ _____
AUTHORIZED SIGNATURE DATE