Patient's Name:____________________________Date:________________________

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED

HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Drs. Warner and Jansen 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. Warner and Jansen 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 HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Drs. Warner and Jansen had acted in reliance upon this authorization. My written revocation must be submitted to Dr. Warner and Jansen's privacy officer at 3320 Tates Creek Road 3rd, Lexington, Kentucky 40502.

This Authorization expires 'one year' from the date the Authorization was signed.

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

Signed by______________________________________

Signature of Patient or Legal Guardian