
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
(PHI)**

I authorize MedPro Rx, Inc. to disclose Protected Health Information for:

Patient's Name _____

Address _____

City/State/Zip _____

Date of Birth _____

Protected Health Information is to be disclosed to:

1. _____
2. _____
3. _____
4. _____
5. _____

I authorize MedPro Rx, Inc to disclose the following Protected Health Information:

- ALL requested information
- _____
- _____

This authorization expires: _____

(If no date is provided, this authorization will expire upon discontinuation of service with MedPro Rx, Inc.)

I understand that I may revoke this authorization at any time by sending written notice to the address above

Patient's Signature _____ Date _____

Responsible Party Signature _____ Date _____
