Imperial Health

DISCLOSURE AUTHORIZATION

☐ I do not authorize ***Imperial Health*** to disclose my Protected Health Information to anyone.

I, _____, authorize ***Imperial Health*** to disclose my Protected Health Information (PHI), (which may include appointments, lab results, imaging results, etc). to:

- ☐ Spouse name:_____
- ☐ Mother name:_____
- ☐ Father name:_____
- ☐ Other: _____

This authorization shall be in force and effect until changed or amended in writing by the person signing this form.

I understand that:

1. Signing this authorization will not effect my treatment.
2. I have the right to receive a copy of this form after I sign it.
3. I may revoke this authorization at any time in writing to the address listed below:

   Imperial Health, LLP
   501 Dr. Michael DeBakey Drive
   Lake Charles, LA 70601
   ATTN: Privacy Officer

_____ _____

Patient Signature Date