Steven D. Graham, Ph.D., D.Min., Inc.
300 South Hyde Park Avenue, Suite 250
Tampa, FL 33606
(813) 732-6717

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Dr. Steven D. Graham to: (circle one)

DISCLOSE TO EXCHANGE WITH RECEIVE FROM

_____
_____

The following protected health care information:
_____
_____

For this purpose:
_____
_____

This authorization will expire on: _____

I understand that:

- I have a right to revoke this authorization **in writing** except to the extent that Dr. Graham has taken action or has relied on the authorization. I may revoke this authorization in writing by delivering a copy of my revocation to Dr. Graham.

- My treatment does not depend on my providing authorization for this use or disclosure of my protected health information.

Signature: _____ Date: _____