Joseph F. Mazza., Jr., M.D., P.A.
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# Authorization for Disclosure of Information

Joseph F. Mazza, Jr., M.D., P.A. will only disclose any and all complete medical information concerning his findings, starting with the initial office visit until the date of the conclusion of his treatment to those individuals who (in his sole determination) are required by HIPPA guidelines to receive such information; for purpose of medical treatment, medical quality assurance including peer review, and medical billing.

I do authorize Joseph F. Mazza, Jr., M.D., P.A. to disclose any and all complete medical information concerning his findings, starting with the initial office visit until the date of the conclusion of his treatment to myself and/or the other's listed below:

**If there are no individuals that you give permission to receive personal medical information, please write NONE on the first available line.**

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

_____
PATIENT'S NAME

_____
PATIENT'S SIGNATURE/GUARDIAN SIGNATURE (if patient is under 18 years of age)

_____
DATE