Limited HIPAA Privacy Release

I (by signature below) hereby authorize and request any and all health care providers (including, but not limited to personal physicians, attending physicians, specialty physicians, hospital clinical or support staff, case managers, and/or ancillary providers) discuss my current medical condition(s), ongoing procedures and treatment plans, as well as any option(s) impacting my current or future care, course of treatment and/or rehabilitation plans with the parties identified below:			
Party 1:	DOB	Phone Number	
Party 2:	DOB	Phone Number	
Party 3:	DOB	Phone Number	
Party 4:	DOB	Phone Number	
This authorization should be deemed primary and enforceable in lieu of any practitioner(s) or facility's release forms customarily required and may be copied and attached thereto as requested. Upon notarization, copies (paper and/or digital) of this authorization should be deemed valid as an original.			
Patient Validation			
Patient named above		DOB	
City	_ State		_
Phone number			
Validating Signature Dated This signature and date must be executed and validated in the presence of a current notary			
Notary Seal/Stamp and Signature			