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RELEASE OF INFORMATION

I hereby authorize The Holman Group to release the following information regarding services provided to me by my **Holman providers.** The process of releasing this information should adhere to the following guidelines:

1. This information is to be given to:

   The treating Medical Doctor

2. Specific type of information disclosed:

   (1) Compliance or con-compliance with treatment plan (2) Prognosis (3) Expected length of treatment (4) Treatment recommendations (5) Disease management logistics

3. The purpose and need for such disclosure:

   Disease Management

4. This consent expires twelve months from date of signature:

Patient's Signature: ____________________________________

Witness' Signature: ____________________________________

Date: ____________________________________

The Authorization authorizes the release of Protected Health Information pursuant to HIPAA regulations contained in 45 CFR Parts 160 and 164. This Authorization also authorizes the release of information under the California Confidentiality of Medical Information Act of 1980, Section 56 et.seq. of the California Code.