Dr. Kevin Killian

625 Salt Lick Road

St. Peters, MO 63376

HIPAA WRITTEN AUTHORIZATION TO APPOVED FAMILY/ OTHER PERSONS

On your authorization:

You may give us written authorization to disclose to persons listed below your health care information. You may revoke this authorization in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in our notice of privacy practices.

Below please list name of person / persons you are authorizing this approval to and your relationship.

_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship
_____	_____
Name of Person	Relationship

_____ _____

Signature Date