Patient Name: _____ DOB: _____

Permission to Discuss Patient Health Information or Patient Account Information

For your protection, we discuss your personal health and financial account information with only those persons you designate. If there is someone you would like to act as your representative with access to either your personal health information or your financial account information, please list their name below.

Name: _____

Allow access to:

Private Health Information: Yes_____ No_____

Financial Account Information: Yes_____ No_____

Name: _____

Allow access to:

Private Health Information: Yes_____ No_____

Financial Account Information: Yes_____ No_____

Name: _____

Allow access to:

Private Health Information: Yes_____ No_____

Financial Account Information: Yes_____ No_____

Patient Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____