PersonalPhysicians
Listening and caring, one patient at a time

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AUTHORIZATION TO RELEASE INFORMATION

I _____, hereby authorize Personal Physicians to use my health care information and may disclose such information to my health insurance (s) for the purpose of obtaining payment for services and determining insurance benefits payable relate to service. I authorize Personal Physicians to release any information acquired in the course of my exam or treatment.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available via mail or in person.

I under that this consent is valid until it is revoked by me, I understand that I may revoke this consent at any time by giving a **written notice** of my desire to do so, to the physician's office. I also understand that I will not be to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I allow you to contact me in the following manner, check all that apply:

Home:

☐ You are permitted to leave a message with detailed information

☐ You are permitted to leave a name and call back number only

Cell:

☐ You are permitted to leave a message with detailed information

☐ You are permitted to leave a name and call back number only

Work:

☐ You are permitted to leave a message with detailed information

☐ You are permitted to leave a name and call back number only

I authorized this facility to release information to (Please check all that apply):

☐ **Spouse**: List complete name of spouse _____

☐ **Children**: List complete names of children & phone number _____

☐ **Others:** List complete name & phone number of person designated _____

☐ **No One**:

_____ _____

Print Name of Patient (Legal Guardian if Under 18yrs.) **Date**

_____ _____

Signature Name of Patient (Legal Guardian if Under 18yrs.) **Date**

Office Staff Initials after Processing: _____

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