AUTHORIZATION FOR DISCLOSURE OF TREATMENT

This signature page is designed for you to establish limitations on what information we can share with people other than your insurance company or Drs. who coordinate your care. If you have certain family members or caregivers that normally assist you in either your health care decisions or financial decisions, you may wish to include them on this form. If you do not authorize anyone on this form, please be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but *you* (including your spouse, siblings, adult children, and caregivers).

I authorize the person(s) named below to discuss my care in my absence and obtain my medical records if necessary (this does not include doctors who are involved in my care). I understand this authorization is in effect unless I revoke the authorization in writing.

Authorized Individuals:

Name	Relationship	Phone

Specific information to be disclosed (check all that apply):

□ Office Notes □ Diagnostic/Imaging

□ Financial/Billing □ Other _____

_____ _____

PATIENT SIGNATURE DATE

Form must be signed and dated each year.