DISCLOSURE OF RECORDS

This form is intended to identify those individuals (family members, close friends, or other persons) to whom we can disclose your protected health information or notify them regarding your care. This form will remain in force until you provide us with written notice otherwise.

Patient Name ____ Date of Birth ___________________

☐ **I am the only person who is to have access to my medical and billing information.**

Emergency Contact:

Name ____

Address ____

Telephone _______________________ Relationship _________________

☐ Emergency Contact Only ☐ May Disclose Medical and Billing Information ☐ May Disclose Medical Information Only ☐ May Grant Portal Access (includes Medical and Billing)

Other Contacts for Disclosure of Records:

1. Name ____

Address ____

Telephone _______________________ Relationship _____________________

☐ Medical and Billing
☐ Medical Only
☐ Portal (included Medical & Billing)

2. Name ____

Address ____

Telephone _______________________ Relationship _____________________

☐ Medical and Billing
☐ Medical Only
☐ Portal (included Medical & Billing)

I agree that protected health information regarding my care and/or treatment may be disclosed to the above-named individuals. This Authorization will remain in effect until I provide written notice to change it.

Print Name ____

Signature ____ **Date** _________________

If this form is being signed by a **Patient's Authorized Representative**, please complete the following:

Representative's Name ____

Relationship to patient and reason for signing: ____

10/17/2025