

PATIENT AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION
FOR TREATMENT AND PAYMENT PURPOSES

In our efforts to keep your health information private, Weiss Medical Associates requests your assistance in completing the following information.

Please identify the name of any member of your household we may speak with concerning your medical care.

Husband/Wife _____ Family Member _____

Son/Daughter _____ Friend/Care Giver _____

Please identify the name of any member of your household whom we may speak with concerning your insurance information or your bill.

Husband/Wife _____ Family Member _____

Son/Daughter _____ Friend/Care Giver _____

You may notify me or the parties listed above to report test results, medication information, billing and/or other Next Step[®] Institute information as follows:

_____ Message on home answering machine/voicemail
Phone number: _____

_____ Message on work voicemail
Phone number: _____

_____ Message on pager
Phone number: _____

_____ Message on cell phone
Phone number: _____

_____ Other: _____
Phone number: _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient—Print Name _____

Patient—Signature _____
(Parent signature if minor)

Date _____