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Associates in Internal Medicine, P.C.
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Patient Authorization to Disclose Information to Specific Individuals

(GW&T # 273300.0-Under " Disclosure for Patients Chart)

Date: _____

I, _____, hereby authorize my physician and/or his/her representatives to disclose
(PRINT PATIENTS NAME CLEARLY)
my medical and financial/billing/insurance information to the individual(s) listed below.

Name of Approved	Relationship	Timeframe (To and From)
1.		
2.		
3.		
4.		

****IF YOU WANT TO AUTHORIZE MORE PEOPLE, PLEASE REQUEST ANOTHER FORM****

PLEASE CHECK OFF THE APPROPRIATE AUTHORIZATION AND/OR LIMITATION FOR THE ABOVE INDIVIDUAL(S). (NOTE TO PATIENT: IF YOU DO NOT WANT STAFF MEMBERS TO BE AUTHORIZED TO DISCLOSE YOUR MEDICAL INFORMATION TO THE AUTHORIZED INDIVIDUAL(S), PLEASE CHECK OFF THE APPROPRIATE LINE DIRECTLY BELOW).

_____ I do not limit this information to a specific timeframe. The practice may disclose past, present and future information to the above named individual(s).

_____ I limit this authorization to the dates noted under " Timeframe. "

_____ I only authorize my physician, not his representatives/staff, to disclose my medical information. I understand that in my physician's absences, one of his partners will need to speak to the individual(s) listed above.

Patients Notes Below (Not Required):

(PATIENTS SIGNATURE)

(DATE)

(SIGNATURE OF WITNESS)

(DATE)