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AUTHORIZATION FOR CONFIDENTIAL COMMUNICATIONS

Patient's Last Name _____ First Name _____ Date of Birth _____

I authorize the following people have my permission to discuss my protected health information with your office and may be in the room with me for my office visits.

First & Last Name _____ Relationship _____

Identity info. needed for verification (i.e., date of birth, address, phone number, etc.) _____

First & Last Name _____ Relationship _____

Identity info. needed for verification (i.e., date of birth, address, phone number, etc.) _____

Patient, parent or guardian Signature _____ Date _____