Authorization to Disclose Health Information:

_____Yes, I authorize Cohesive Family Medicine to leave me voice messages regarding my protected health information as stated below.

_____ No, I do **NOT** want Cohesive Family Medicine to leave me voice messages.

Patient or Guardian Signature:_____ Date:_____

I hereby authorize Cohesive Family Medicine to release my health information as described in: Medical or Billing

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Protected health information may include info/documents regarding medical treatment of the patient including but not limited to diagnosis, procedures, treatment plans, appointments, and test results. As well as account and billing information, including but not limited to, account balances, payment arrangements, insurance claims status and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations govern the terms of the authorization. I understand that I have the right to revoke this authorization at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing.

Signature of Patient or Guardian:_____

Relationship of the Guardian:_____Date:_____

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