NEIL A . PATTERSON, M.D., P.A.

PATIENT CONSENT FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION TO NON-MEDICAL ENTITIES

Completion of the following sections provides consent for representatives of Neil A. Patterson, MD, PA to perform certain actions. Please review carefully.

DISCLOSURE

THIS FORM ALLOWS FOR OTHER PEOPLE TO BE PRIVY TO YOUR PERSONAL HEALTH INFORMATION WHICH INCLUDES: TELEPHONE MESSAGES, TEST RESULTS, PICKING UP PRESCRIPTIONS, RECORDS, LABS, REFERRALS AND MEDICAL RECORDS.

I give my consent to release my private health information (PHI) to the following person(s):
(***Write "None" if disclosure is only to patient.***)

Name(s)/SS#_____

_____

_____

I understand that I may change my consent except to the extent that disclosures have already been made based upon any prior consent I gave in the past.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Name of Patient Print Name of Legal Guardian