

Tri-State Maternal-Fetal Medicine Associates

PERMISSION TO DISCUSS MY HEALTH INFORMATION

_____,
Patient Name (Please Print)

_____,
Date of Birth

Phone

To assist me with my healthcare and payment, I give permission to Tri-State Maternal-Fetal Medicine to discuss the following types of information: (check as many as apply)

- Appointments
- Billing Information/Statements/Insurance Claims
- Clinical Information
(diagnosis, prognosis, medications, type of illness, test results, treatments, etc.)

With the following individuals:

_____,
Name (Please Print)

_____,
Relationship to Patient

_____,
Name (Please Print)

_____,
Relationship to Patient

_____,
Name (Please Print)

_____,
Relationship to Patient

Please list any phone numbers where we may leave a **voice message** regarding private health information:

(Home)

(Work)

(Cell/Other)

This permission has no expiration unless otherwise noted here: _____

I understand that I have the right to withdraw this permission at anytime in writing. I understand that it is my responsibility to inform, Pam McClintock, Practice Manager for Tri-State Maternal-Fetal Medicine Associates, in writing of any changes to this permission.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date