



Authorization to Release Information

Patient Name: (Please Print) _____ DOB: _____

My signature below indicates my agreement to the following (check each applicable item):

- I am treated by multiple providers in the Tahoe Forest Multispecialty Clinics. This form applies to all of those providers.
- This form applies only to: _____ (provider name)

Protected Health Information: Please indicate with whom we may discuss your Protected Health Information (*i.e. spouse, partner, child, parent, friend, etc.*):

- None, discuss only with me.
- You may discuss my Protected Health Information with the following person(s):
 Name: _____ Relationship: _____
 Address: _____
 Phone Number(s): _____
 - I want this Authorization to end on (date): _____
 - There is no end date.

Insurance/Billing Information: Please indicate with whom we may discuss insurance and billing matters (*i.e. spouse, partner, child, parent, friend, etc.*):

**Please note that the provisions of your insurance policy, and applicable regulations, may permit us to discuss insurance/billing information with persons not indicated here.*

- None, discuss only with me.
- You may discuss my Protected Health Information with the following person(s): **Write "Same" if same as above.**
 Name: _____ Relationship: _____
 Address: _____
 Phone Number(s): _____
 - I want this Authorization to end on (date): _____
 - There is no end date

DO NOT release information to: Name: _____ Relationship: _____
Address: _____ Phone Number: _____

Signature of Patient or Authorized Representative: _____ Date: _____

Print Name: _____ Relationship: _____

Witness: _____ Date: _____