TAHOE FOREST WOMEN'S CENTER

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:_____