Hillcrest Family Medicine, P.A.

Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Receive Information:

Any health information Hillcrest Family Medicine, P.A. collects or receives about you may be disclosed to the following persons:

_____
Name of person / relation

_____
Name of person / relation

_____
Name of person / relation

_____
Fax Number(s)

Use and Disclosure of Information:

____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Hillcrest Family Medicine, P.A.

____ I do not authorize any information to be disclosed to any other parties except those parties outlined in the *Notice of Privacy Practices*.

If you have an answering machine or voice mail, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Hillcrest Family Medicine, P.A.

_____YES _____NO _____N / A

If "NO", how may we contact you regarding this information?

_____

Expiration Date of Authorization
This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name of Patient or Legal Representative Print Name of Witness