GRAVES GILBERT CLINIC

Patient Name: _____

Patient Date of Birth: _____

Dear Patient:

In order to help us stay within the guidelines of HIPAA, please list any person/persons below that you authorize our office to disclose information to regarding your protected health information. We will not be able to disclose any of your personal health information or appointment information to anyone other than those listed below. **(You do not need to list any of your doctors, workers compensation carrier, auto insurance or lawyer's office.)**

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Do we have your permission to leave information from our office on your answering machine/voicemail when you are unable to answer the phone? (Please circle) YES NO

_____ _____

Patient Today's Date

Valid until revoked by patient Scan to HIPAA Release (HI)