STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date: _____

I hereby authorize the office of Choice Physicians, PLLC, Camilo Ruiz, D.O., P.A., and/or Tiffany Sizemore, D.O., P.A. to disclose any patient medical information for the above named patient via any of the methods designated below:

My telephone number at:

[ ] HOME_____

[ ] WORK_____

[ ] CELL _____

[ ] EMAIL_____

Please indicate by checking the boxes above where we may leave a message regarding your medical results.

List any person(s) if they are authorized patient representatives I.e., caregiver, power of attorney, etc.

Name of Representative: _____

Relationship of Representative to Patient: _____

Method of Contacting Representative:_____

Name of Representative:_____

Relationship of Representative to Patient:_____

Method of Contacting Representative: _____