



Patient Confidentiality

A part of our “Pledge to Our Patients” we state...”your personal privacy will be maintained and all information and records about your care is kept confidential”.

You may find it suitable to discuss your care with other individuals, including but limited to a significant other, or family member. You may update this form, in writing, at any time.

Please complete the following:

- I **DO NOT** want any information regarding my care released to anyone except myself. I do authorize release to the Health Care Financing Administration and/or my insurance carrier and its agents any medical information about me to determine the payment for related services.
- I authorize you to discuss **ANY information** regarding my care to the following individuals, in addition to, the Health Care Financing Administration and/or my insurance carrier and its agents to determine the payment for related services.

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Patient Name (Printed) Signature Date