ethos

HIPAA Contact Release Form

In order for us to stay within guidelines of HIPAA, please list below any person/persons that you authorize us to disclose information to regarding you Protect Health Information, including billing information.

Name	Relationship	Phone
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____

I understand that I may rescind permission at any time by notifying the office.

_____ _____

Patient's Name (Please Print) Date of Birth

_____

Patient's Signature (or Guardian) Date