Authorization for Verbal Disclosure of Information (Optional)

I , _____ / _____
(Patient Name / please print) (Date of birth)

I authorize the Twin Cities Spine Center to discuss my health information on my behalf with the following individual(s) (i.e., spouse, partner, family member, friend, etc)
Do not include physicians, attorneys or insurance companies on this sheet.

1) _____ / _____ / _____
(Name / please print) (Relation to Patient) Contact Number

2) _____ / _____ / _____
(Name / please print) (Relation to Patient) Contact Number

3) _____ / _____ / _____
(Name / please print) (Relation to Patient) Contact Number

Health information may include billing and medical health information, as well as information regarding your health status, appointment and surgery scheduling, or any other information pertaining to your care while at the Twin Cities Spine Center.

I understand the information used or disclosed, based on this authorization, may possibly be re-disclosed by the recipient, and/or no longer protected by Federal Privacy standards.

I understand that written notification is needed to revoke this authorization and I may do so at any time.

_____ _____
Signature of patient **Date**

Place Label Here