ESSENTIAL HEALTH ACCESS, P.A.
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____

PATIENT SOCIAL SECURITY # _____ - _____ - _____

Please list any person that we may communicate with in relation to your medical condition or treatment and also that we could discuss your account with. For example, spouse, children, mother, father, sister, brother, etc.

Please understand that if you do not list anyone below then we will not be able to communicate with anyone but yourself regarding your protected health information.

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I understand that this authorization will expire on an indefinite period.
I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying ESSENTIAL HEALTH ACCESS, P.A. in writing.
I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable)
I may inspect or copy any information used or disclosed under this agreement.
I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
Patient signature or Patient Representative Signature Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient