MOWERY CLINIC
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Printed Name of Patient ______________________ Patient's Date of Birth ______________ Patient's Social Security # ______________

Printed Name of Person Submitting Request (if other than Patient) ______________________ Relationship to Patient ______________

AUTHORIZATION TO RELEASE INFORMATION:
I, hereby, authorize Mowery Clinic, L.L.C., its physicians and/or staff to share either verbally or otherwise diagnostic reports, other medical information and all relevant portions of medical record information about me or the above named patient for whom I possess parental custody or other legal authority to:

First and Last Name	Relationship to Patient

NOTE: No verbal or phone message(s) will be left with any individual other than yourself or those persons listed above.

RESTRICTION ON RELEASE OF PROTECTED HEALTH INFORMATION:
Do not without separate specific written authorization, release Protected Health Information about me or the above name patient for whom I possess parental custody or other legal authority to the following identified physicians, hospitals, other health care providers, insurors or other individuals.

______________________ Complete Name and Address

______________________ Complete Name and Address

______________________ Complete Name and Address

ALTERNATE COMMUNICATONS:
I, hereby, authorize Mowery Clinic to contact me via the following methods of communications with regard to my Protected Health Information (PHI) or the PHI of the above named patient (this includes, but is not limited to appointments, test results, etc.).

		Circle One	
______________ Home Phone Number	May messages be left on your home phone answering machine?	YES	NO
______________ Work Phone Number	May messages be left on your voice mail at work?.	YES	NO
______________ Cellular/Other Phone Number	May messages be left on your voice mail on your mobile or other number listed at left?	YES	NO
______________ e-mail	May messages be sent to the e-mail address at the left?	YES	NO

I understand that this authorization will be in effect for the duration of treatment and follow up unless terminated by me in writing.

______________________ Patient Signature/Patient Representative ______________ Date