Maple Street Medical Group

Authorization for Non-Routine Disclosures

FAMILY/FRIENDS ONLY

Last Name:___________________________ First Name:______________________ M.I.__________

Preferred Phone Number:(_______)_____________________ DOB:________________

I authorize information to be disclosed to the following people:

Name:____ Relationship to Self:_________________

Phone # ___________________ Type of information to be disclosed. (Check all that apply)

☐ Appointment/Reminder ☐ Labs ☐ Medications

☐ Billing ☐ Clinical Findings ☐ Treatment

Name:____ Relationship to Self:_________________

Phone # ____________________ Type of information to be disclosed. (Check all that apply)

☐ Appointment/Reminder ☐ Labs ☐ Medications

☐ Billing ☐ Clinical Findings ☐ Treatment

Name:____ Relationship to Self:_________________

Phone # ______________________ Type of information to be disclosed. (Check all that apply)

☐ Appointment/Reminder ☐ Labs ☐ Medications

☐ Billing ☐ Clinical Findings ☐ Treatment

☐ I do not authorize any information to be disclosed to anyone but myself.

Please be aware you will be asked to confirm or change this information yearly.

____ ___ ____________________________

Signature of Patient or Patient's Representative Date

____ ___ ____________________________

Printed name of Patient or Patient's Representative Relationship to Patient