Robert M. Rogers, M.D., P.A.
Authorization to Disclose Information

Disclosure of Medical Information: (Choose One Option)

____ I DO want information released to the following persons (Please list the individuals with whom we are authorized to discuss your care):

Name	Relationship	Phone #
Name	Relationship	Phone #

____ I DO NOT want my information released to anyone other than myself.

Communication and Messages: List the phone number(s) where you can be reached between 8am-5pm Monday through Friday.

Primary #_____ Secondary #_____

If we are unable to reach you personally at the number(s) listed above **choose one option below**:

____ I DO authorize information regarding myself regarding my care or billing to be left on the answering machine or voice mail.

OR

____ I DO NOT authorize information regarding myself regarding my care or billing to be left on the answering machine or voice mail.

I authorize the use or disclosure of the personal health information as described above by Robert M. Rogers, M.D., P.A. I understand that the privacy practices followed by Robert M. Rogers, M.D., P.A. are available to me at any time upon my request. I understand that Robert M. Rogers, M.D., P.A. cannot discuss my medical information with anyone I have not listed above. I also understand that I may revoke the authorizations set forth above at any time by notifying Robert M. Rogers, M.D., P.A. in writing. If I choose to do so, I understand that my revocation will not affect any actions taken by Robert M. Rogers, M.D., P.A. prior to its receipt of my written revocation.

Patient Name: _____ Date of Birth:_____

Signature: _____ Soc. Sec. #:_____
(or Parent or Power of Attorney)

Dated:_____