BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize OSPT to disclose my health information that is directly related to my current treatment at OSPT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the individuals below even though involved in my care.

NAME	RELATIONSHIP

_____ _____

Signature of Patient (or Patient's Representative) **Date**

_____ _____

Signature of Witness (OSPT Staff) **Date**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of Attorney ☐ Guardian ☐ Surrogate Decision-Maker
☐ Executor of Legal Rep. ☐ Parent ☐ Other (please specify) _____

_____

Provide documentation or explanation of your authority to act for the patient

_____