Personal Health Information Disclosure Agreement for Bowling Green Internal Medicine & Pediatric Associates

I, _____, do hereby grant permission for Bowling Green Internal Medicine & Pediatric Associates, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- ❑ **Appointment dates and times** ❑ **Treatment plans and referrals**
- ❑ **Financial and billing information**
- ❑ **Any other pertinent health information related to treatment at this office.**
- ❑ ❑ **None of the above**

I understand that this permission will remain in effect unless a written cancellation has been provided to Bowling Green Internal Medicine & Pediatric Associates.

_____ _____

Patient Signature **Date**

_____

Patient's Date of Birth

_____ _____

Witness Signature **Date**