CONSENT TO DISCLOSE CLINICAL PROTECTED HEALTH INFORMATION TO A DESIGNATED REPRESENTATIVE

Patient Name: ______________________________ MRN: ________________________

Address: ____

City, State: ________________________________ Zip: __________________________

To be completed by Patient

I,____, hereby authorize my provider,
Print Patient's Name

____, at Athena Medical to release protected
Print Provider Name

health information regarding me or my condition/treatment ______________________to:

_______________________________________ my ______________________________
Print Name of Representative Relationship to Patient

_______________________________________ my ______________________________
Print Name of Representative Relationship to Patient

_______________________________________ my ______________________________
Print Name of Representative Relationship to Patient

_______________________________________ ______________________________
Patient's Social Security Number Patient's Date of Birth

_______________________________________ ______________________________
Signature of Patient Date Signed

_______________________________________ ______________________________
Signature of witness Date Signed