Barrington Surgeons, Ltd.
PATIENT INFORMATION AUTHORIZATION

I, _____ authorize the methods of communication of my protected health information (PHI) as indicated below. I understand under HIPAA guidelines, my patient information is held confidential unless authorized by my signature.

The following person(s) can inquire, pick up records, prescriptions, etc. and take messages regarding my health information:

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

4) _____ Relationship: _____

Barrington Surgeons, Ltd. is authorized to communicate PHI such as test results, physician messages, or appointment information. Please initial each appropriate line that you authorize.

_____ Telephone answering machine

_____ With person listed above

_____ Mail to: ( ) Home ( ) Office

_____ Fax Machine

Patient Signature: _____ Date: _____

Patient Name: _____

Signature Update: _____ Date: _____

Signature Update: _____ Date: _____

Signature Update: _____ Date: _____