PHYSICIAN OFFICE
AUTHORIZATION TO SHARE
MEDICAL AND BILLING INFORMATION

I, _____, the undersigned, hereby authorize Esse Health, its representatives, physicians, and staff to share any and all medical and billing information with the following individual(s):

Name: _____ Relationship to patient_____

Information that may be shared with this individual: ___ medical ___ billing

Phone: HM_____ Cell_____ WK_____

Name: _____ Relationship to patient_____

Information that may be shared with this individual: ___ medical ___ billing

Phone: HM_____ Cell_____ WK_____

Name: _____ Relationship to patient_____

Information that may be shared with this individual: ___ medical ___ billing

Phone: HM_____ Cell_____ WK_____

Authorized by:

_____
PRINT PATIENT NAME DATE OF BIRTH

_____ _____
PATIENT SIGNATURE DATE

I understand that I may revoke this authorization at any time by signing in the designated space below.

I hereby revoke this authorization.

_____ _____
PATIENT SIGNATURE DATE