

John E. Bubser D.P.M., P.A.

Authorization for the Sharing of Protected Health Information

Name: _____

DOB: _____

Home Phone Number: _____

The providers/staff of John E. Bubser D.P.M., P.A.
may discuss my medical condition and/or history with:

NAME	RELATIONSHIP
_____	_____
_____	_____

If I DO NOT WANT certain information about me disclosed, I will list it below:

Patient Signature
(Parent/Legal Guardian or Appropriate Consenting Party)

Relationship Date

EXPIRATION: This authorization expires no later than one year from the date it was signed.

THIS CONSENT MUST BE MAINTAINED FOR 6 YEARS

INITIAL OF PERSON TAKING REQUEST: _____