ROBERT L. BORENITSCH D.O.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Robert L. Borenitsch D.O., to use and/or disclose certain protected health information (PHI) about me to the following person/persons

________________________________ ____ Spouse ____ Parent ____ Other
Name

________________________________ ____ Spouse ____ Parent ____ Other
Name

____
Name of Physician Address Phone

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Name of Physician Address Phone

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Name of Physician Address Phone

This authorization permits Robert L. Borenitsch D.O., to use or disclose the following individually identifiable health information about me

____ Medical Information ____ Insurance Information

____ Appointment Information

The information will be used or disclosed for the following purpose **MEDICAL CARE.**
This authorization will expire on **AT END OF TREATMENT.**

SIGNED BY: ________________________________ ____________________
Signature of Patient or Legal Guardian Relationship to Patient

________________________________ ____________________
Patient's Name Date