Farinna Willis, M.D., P.C.

Patient Contact Information Sheet

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of **Farinna Willis, M.D., P.C.** has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information (PHI) with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I also understand that I can refuse to sign this form. I can also revoke it by submitting a letter to **Farinna Willis, M.D., P.C.** or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual (s) it may be subject to redisclosure by the individual(s).

I also understand that I have rights as to the type of information disclosed and I do not want the following information about my PHI to be released without notifying me first _____ (initial) or I do not want the following information released _____ (initial)

- Financial status of your account
- Medical Diagnosis, Prognosis or Condition
- Test Results (mammograms, pap smears, sexually transmitted infections, etc.
- Medications
- Psychological diagnosis

By signing you are stating that you have read, understood and agree with the above information.

Patient Signature: _____ Date: _____