ASHLEY CLINIC
PERMISSION TO SHARE INFORMATION

Patient: _____ **Last 4 digits of SSN:** _____ **Account #:** _____

Ashley Clinic may share and/or discuss my protected health information, financial and/or insurance information with the following:

YES NO

☐ ☐ Spouse _____
(Full Name and Last 4 Digits of SSN)

☐ ☐ Mother _____
(Full Name and Last 4 Digits of SSN)

☐ ☐ Father _____
(Full Name and Last 4 Digits of SSN)

☐ ☐ Children _____
(Full Name and Last 4 Digits of SSN)

☐ ☐ Other _____
Name Relationship Last 4 Digits of SSN

_____
Name Relationship Last 4 Digits of SSN

Information to Be Disclosed (Check all that apply):
☐ Medical records
☐ Billing / financial records
☐ Appointment details / scheduling
☐ Insurance information
☐ Lab and test results
☐ Prescription/medication information
☐ Other (please specify): _____

Purpose of Disclosure:
☐ Continuity of care
☐ Legal
☐ Billing / insurance
☐ Personal use
☐ Other: _____

Authorization Expiration:
This authorization will remain in effect for one year from the date signed.

Revocation & Patient Rights
- I understand that I may revoke this authorization at any time by submitting a written request to Ashley Clinic.
- Revocation will not affect disclosures already made in reliance on this authorization.

Authorization
By signing below, I authorize Ashley Clinic to share my information as indicated above with the individuals listed. I acknowledge that I have read and understand this authorization.

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Patient Representative (print): _____ Relationship: _____

Witness: _____ Title: _____ Date: _____