

ASHLEY CLINIC

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
John Doe	Spouse	1234
Jane Doe	Spouse	5678
Bob Smith	Spouse	9012
Alice Johnson	Spouse	3456
Charlie Brown	Spouse	7890
Diana Prince	Spouse	2345
Edward Nigma	Spouse	6789
Fiona Glenanne	Spouse	0123
George Costanza	Spouse	4567
Helen Mirren	Spouse	8901
Ian McKellen	Spouse	2345
Jennifer Lawrence	Spouse	6789
Keanu Reeves	Spouse	0123
Liam Neeson	Spouse	4567
Mel Gibson	Spouse	8901
Nicole Kidman	Spouse	2345
Orlando Bloom	Spouse	6789
Penelope Cruz	Spouse	0123
Robert Pattinson	Spouse	4567
Sandra Bullock	Spouse	8901
Tom Cruise	Spouse	2345
Uma Thurman	Spouse	6789
Will Smith	Spouse	0123

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
☐ Billing / insurance
☐ Other: _____

☐ Legal
☐ Personal use

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: _____