Andrea M. Williams, MD
www.docsinus.org

Permission to Communicate (speak with listed individuals about your health and financial status)

In signing this authorization to release my protected health information I acknowledge that I have read and understand my rights to medical information confidentiality and authorize ENTAAC/CSC to discuss my health issues. I also authorize ENTAAC/CSC to discuss any financial information regarding my account with the following listed individuals only:

____

Name /Relationship

____

Name / Relationship

____

Patient Signature   Date

Consent for Treatment of Minor (who is allowed to accompany patient under the age of 18)

If the patient is a minor, please use the lines below to document all those that can accompany the patient/minor to the appointment and have access to personal medical records.

____

Name /Relationship

____

Name / Relationship

____

Patient Signature Date   Date

07/2022