Acton Medical
ASSOCIATES
Adult & Pediatric Primary Care

CONSENT TO DISCLOSE HEALTH INFORMATION
FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name: _____
Last First Middle

Home Address: _____
City/Town State Zip

Home Telephone: _____ Date of Birth: _____

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize AMA to disclose my medical information so that AMA may treat me, seek payment from third parties for such treatment, and generally carry on AMA's health care operations (e.g. quality assurance). I also authorize AMA to disclose my medical information to insurers and providers outside of AMA when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care options.

_____I authorize AMA to disclose my medical information on my home answering machine/voice mail

_____I authorize AMA to disclose my medical information to the person(s) listed herein:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

_____ _____
Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____
Signature of Personal Representative | Description of Authority | Date