PATIENT REPRESENTATIVE AUTHORIZATION

Dr. John M. Henderson DO PC

1900 10th Ave, Suite 320

Columbus, GA 31901

I hereby give **Dr. JOHN M. HENDERSON DO PC** (The Practice) to discuss my medical history, current treatment plan(s), and any other details of my care, not otherwise restricted in writing, with the following individual(s). I understand that all applicable HIPAA rules and regulations will be followed. I understand that this authorization can be changed or revoked at any time by notifying **The Practice** by telephone **(706) 323-5717**, fax **(855) 681-1414**, email **jhendersondo@hendersondo.net**, or in person at the office front desk.

Individual 1: **Exp of Authorization:**

Relation to Patient:

Individual 2: **Exp of Authorization:**

Relation to Patient:

Individual 3: **Exp of Authorization:**

Relation to Patient:

Individual 4: **Exp of Authorization:**

Relation to Patient:

Individual 5: **Exp of Authorization:**

Relation to Patient:

Restricted Information:

Patient Signature:_________________________

Patient Name:

DOB:

Responsible Party Signature:___________________________

Responsible Party Name: