Dr. Jodi Berg
Integrative Family Health Clinic

Authorization for Peer-to-Peer Consultation & Disclosure of Medical Information

I, _____ **(Patient Name)**, authorize **Dr. Jodi Berg** of **Integrative Family Health Clinic** to contact and participate in a peer-to-peer consultation with the physician listed below regarding my medical care.

I authorize Dr. Jodi Berg to disclose and discuss my protected health information (PHI), including my medical history, diagnoses, medications, laboratory and imaging results, treatment plans, clinical notes, and any other information reasonably necessary for my care, treatment, or insurance authorization.

I understand that this authorization is voluntary, may be revoked at any time by providing written notice (except to the extent that action has already been taken in reliance on this authorization), and is valid only for the peer-to-peer consultation described above unless revoked earlier.

I understand that my insurance **may or may not** cover the cost of the peer-to-peer consultation or related services, and I agree to be financially responsible for any charges not covered by my insurance.

Patient Information

Patient Name (Print): _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Consulting Physician Information

Physician Name: _____

Clinic Name: _____

Address: _____

Phone: _____ **Fax:** _____