Patient Consent to Disclose Protected Health Information (PHI) and Billing Information to a Designated Representative

____
Patient Name (*Please print*)

____ ________________________
Address DOB

________________________ ___________________ _________________________
City State Zip

I hereby give consent to provider _____________ (*name of provider*) to release protected health information (PHI) as indicated below to the following representative(s), outside requestor(s), and/or other provider(s).

Place check the information for requested disclosure:
_____Medical Information ONLY _____Billing Information ONLY _____Both medical and billing information
_____Other (Specify):____

Designated Representative Name	Relationship to Patient	Phone number	Emergency Contact
__________________	__________	__________	Yes No (circle one)
__________________	__________	__________	Yes No (circle one)
__________________	__________	__________	Yes No (circle one)
__________________	__________	__________	Yes No (circle one)

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to: Dorfcorp LLC dba Texoma Primary Care 5500 Kell West Ste 100 Wichita Falls, TX 76310**
- **If I cancel the consent, it will NOT apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand that I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**

Signature: ____

Printed Name: ____ Date Signed ____________________

Relationship to Patient: ____

Reviewed by: ______________________________ ___________________________________
Staff Name (Please print) Date