Authorization of Disclosure of Information

Patient Name:___________________________ Date of Birth: _______________________

I hereby request that the following person(s) be identified as participants in my care or payment process. I understand that I am authorizing West Bend Medical to disclose health care information to the person(s) identified below to facilitate those individual involvement in my healthcare. West Bend Medical will make a reasonable effort to provide only the necessary information to the person(s) for this use and disclosure.

Name	Relationship	Phone Number	Type of information to be released

Authorization of Treatment of Minors

I authorize the following person(s) to bring my son/daughter ________________________, to their medical appointment. I also authorize any medical treatment that is necessary.

Name	Relationship	Phone Number

1. I understand that this authorization will: (must check one)
   __ expire 1 year from the date signed by the patient or patient's representative
   or
   __ be effective for the lifetime of the patient unless revoked (or if a minor, until age 18)
   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying West Bend Medical in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by West Bend Medical prior to their receipt of the revocation.
   Initials: _____

3. I understand that my treatment is not conditional upon whether I sign this authorization.
   Initials: _____

________________________________ ________________________

[Patient or Personal Representative Signature] [Date]

____

If Personal Representative, describe relationship