24 E. Front Street, Suite 106
Pataskala, OH 43062
740-777-9039 (p)
740-7779041 (f)

Approved HIPAA Alternates

I, _____ on this _____ day of _____, 20 ____ hereby authorize AffirmHD and its agent to release information in regard to my health and health related concerns to the following persons as listed below in the event that I cannot be reached or you are attempting to reach me.

Name: _____
Phone: _____
Relationship: _____

____ All information ___ Leave a message for callback only

Name: _____
Phone: _____
Relationship: _____

____ All information ___ Leave a message for callback only

Name: _____
Phone: _____
Relationship: _____

____ All information ___ Leave a message for callback

If there are any questions, please call the office. Due to HIPAA regulations, we require a signed release of information to discuss any confidential medical information.