1700 East 9th Ave
Winfield, KS 67156

Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate (**This is not for access to your Medical Records**) on your behalf with Hillside Medical Group, PA. This form when signed allows Hillside Medical Group, PA to this authorized person about your personal information concerning insurance benefits, payments, treatment or any other health care information regarding your care.

_____ _____ _____ ___/___/_____ _____

First Name **M** **Last Name** **DOB** **SSN#**

I hereby give my consent for Hillside Medical Group, PA to communicate personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to Hillside Medical Group, PA 1700 East 9th Ave Winfield KS 67156. This authorization allows Hillside Medical Group, PA to speak with the authorized person(s) regarding: Treatment, insurance claims, copays or any other aspects regarding care. This consent is valid until it is revoked by the patient. It is the patients' responsibility to let Hillside Medical Group, PA know if they would like to change or revoke this form.

Signature:_____ Date:_____

Person(s) Authorized to speak with Hillside Medical Group, PA

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Hillside Medical Group, PA
1700 East 9th Ave
Winfield, KS 67156
www.hillsidemedgroup.com
Phone: 620-221-0110
Fax: 620-221-0623

Witness: _____ Date: _____

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