



Watertown Medical Associates

Maximilian Gomez-Trochez, MD

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This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient: _____

Date of Birth: _____

I. My Authorization

I authorize the following using or disclosing party: _____ to use or disclose the following health information to:

MAXIMILIAN GOMEZ-TROCHEZ, MD, Kaitlyn Finneran, APRN :

365 MAIN ST. STE 201 WATERTOWN, CT 06795 : TEL: 860-274-2418 FAX: 860-274-2986

- All of my health information

- My health information relating to the following treatment or condition:

- My health information covering the period from _____ (date) to _____ (date)

- Other: _____

The purpose of this authorization is (check all that apply):

- At my request

This authorization ends:

- On (date) _____

Signature of Patient: _____

Date: _____