Watertown Medical Associates

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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 Maximilian Gomez-Trochez, MD , Kaitlyn Finneran, APRN to disclose the following health information to:

_____

_____

☐ - 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: _____