Prairie Clinic

HEALTH CARE INFORMATION COMMUNICATION AUTHORIZATION

I _____ , _____ give my
name date of birth
authorization for my doctor or any member of Prairie Clinic staff to discuss my health care with the following individual(s):

1) _____ 2) _____

This authorization to include
_____ Information regarding all aspects of my health care.
_____ Information limited to : _____.

I authorize Prairie Clinic staff to leave a message on my answering machine if necessary.
Yes_____ No _____

This authorization is in effect until revoked by me.

_____ _____
Patient signature Date signed

_____
Witness