Authorization of Use and Disclosure of Protected Health Information

I, _____, give Monarch Healthcare authorization to use and/or disclose my protected health information to the individuals listed below (doctor's office, parent, spouse). I understand if their names are not listed below, no information will be shared without a signed consent.

Name	Relationship to Patient	Phone number

This authorization shall remain in effect until revoked or terminated by the patient or the patients parents personal representative. You may revoke or terminate this authorization by submitting a written revocation to Monarch Healthcare.

Alternate Means of Communication

You may request to receive confidential communications involving your protected health information by alternative means. Please list below the numbers at which you would like to be contacted and indicate at which at which number(s) messages may be left by checking the "Message Ok" box.

Home: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Work: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Cell: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Fax: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Other:_____

Signature:_____ Date:_____

Relationship if representative:_____