DISCLOSURE AUTHORIZATION

As stipulated by the HIPAA privacy rule, patients have the right to control how and to whom their protected information is given. Please instruct as to how you would like the staff of Aaron Boone, DO & Associates, PLLC to contact you.

Please contact me in the following manner (check all that apply)

☐ **Home/Cell telephone**_____ ☐ **Work telephone**_____

- ☐ May leave detailed message
- ☐ Leave message with call back number only
- ☐ May leave detailed message
- ☐ Leave message with call back number only

Written Communication

- ☐ Mail to my home address _____
- ☐ Mail to my work address _____
- ☐ Fax to this number _____

In order to further protect your privacy, we will only disclose your healthcare information to the family members (or others close to you) if you authorize us to do so. Therefore, if you permit us to share your medical information with others on a regular basis, please list their names below.

Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number

This authorization is effective from _____ until_____
(Effective date) (Expiration date)

Print Patient Name _____ Date of Birth _____

Signature of Patient, Parent, or Legal Guardian _____ Date _____

Description of Personal Representative Authority _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following address or phone number:
Aaron Boone, DO & Associates, PLLC
5901 South Cooper Street, STE 101, Arlington, TX 76017. (817) 200-7088 or Fax: (817) 241-6117