Delphi
Enhanced Primary Care

In affiliation with Orchard Medical Group

(Form Optional)

Authorization to Disclose Health and/or Financial Information

Patient Name : _____

Date Of Birth : _____/_____/_____

Other than the patient, insurance company, and healthcare providers involved in the patient's care, whom can we talk with about healthcare information and/or financial information?

Name : _____

Relationship : _____ Phone # : _____

Name : _____

Relationship : _____ Phone # : _____

Name : _____

Relationship : _____ Phone # : _____

Required Signature for ALL Patients:

_____ Date : _____

Signature of Patient or Legal Representative

_____ _____

Name of Legal Representative Relationship to Patient