Personal Health Information Disclosure Agreement for
Rosenberg Center/Barron Psychological Services/Tannahill Medical Services

I, ______________________________, do hereby grant permission for Rosenberg Center/Barron Psychological Services/Tannahill Medical Services, to disclose my protected health information to the following personal representatives(s): (i.e. spouse, parent, child).

Name: **Relationship:**

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Information to be disclosed (please check):

_______Appointment dates and times

_______Treatment plans and referrals

_______Financial and billing information

_______All other pertinent health information related to treatment at this office

_______All of the above

_______None of the above

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I understand that this disclosure agreement will remain in effect for one year unless a written cancellation has been provided to Rosenberg Center/Barron Psychological Services/Tannahill Medical Services.

____ __________________
Patient Signature Date

____ __________________
Patient's Written Name Patient's Date of Birth

STAFF USE ONLY:

- Add disclosure information to PF (names, information, expiration date)

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  (staff initials once added to PF)