Shanahan Rheumatology & Immunotherapy, PLLC

Authorization for Individuals to Receive Patient Information & Obtain Medications on Patient's Behalf

Personal Information: **Date:** _____

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____/_____/_____

Individuals Authorized to Receive Patient Information & Obtain Medications on Patient's Behalf (please do not include other healthcare providers):

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Authorization for Release of Information:

I give my permission to Shanahan Rheumatology and Immunotherapy to discuss my care with the individuals listed. This authorization is valid from today until revoked in writing as long as I am a patient of this office. I understand that I may authorize additional recipients at any time.

Signature of Responsible Party:

_____ Date: _____ Time: _____

Printed name (if not patient): _____

Relationship to patient: _____