# Patient Representative Release Authorization

By completing this form I authorize Dr. Warren Klausner to discuss my protected health information with one or more of the representatives identified below.

I may add or delete up to three individuals at any time by completing this authorization. I authorize the office of Dr. Warren Klausner to discuss my medical care without restrictions with the individuals identified below. I understand there is no expiration date and I may change (add or delete) up to three individuals at any time by completing a new authorization form. I understand that revocation of an individual will not apply to information that has already been provided in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization or identify any representatives.

## Patient Information:

Name ( please print) : _____

Date of Birth: _____ Telephone Number: _____

Address: _____

Signature of Patient: _____ Date: _____

## Patient Representatives:

Identify up to three individuals to be your patient representatives or write N/A if you choose not to have any. Please include a phone number for each.

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Each designated representative will need to provide the your name, address, telephone number and date of birth prior to Dr. Klausner or his staff discussing any personal health information on your behalf.