Right of Access

Patient Name: _____ Date of Birth: _____/_____/_____

I authorize Meritage Medical Network to disclose my medical and billing protected health information involving treatment and payment to the following people:

☐ Spouse/ Partner: _____ _____
Name Contact Information

☐ Child(ren): _____ _____
Name Contact Information

☐ Other: _____ _____
Name and Relationship Contact Information

☐ Other: _____ _____
Name and Relationship Contact Information

If there is specific protected health information you wish us to **NOT** disclose, please specify here:

_____

_____

_____

This **Right of Access** authorization disclosing your protected health information, as noted above, will remain in effect until terminated by you, the patient, who is authorizing access.

_____ _____
Patient Signature Date Signed