Patient Name_____ DOB_____

Permission to disclose to those involved in my care

Ottawa Family Physicians, Chtd.
1418 S. Main, Suite 5
Ottawa, KS 66067

I hereby allow Ottawa Family Physicians, Chtd., to disclose the following Health information:

- ❑ **Appointment times and dates**
- ❑ **Tests that have been received**
- ❑ **Test results**
- ❑ **Financial / business office information**
- ❑ **Other health information**

To the following people because they are involved with my health care or payment:

❑ **Spouse** **Name:**_____
Phone:_____

❑ **Friend** **Name:**_____
Phone:_____

❑ **Child** **Name:**_____
Phone:_____

❑ **Other** **Name:**_____
Phone:_____

_____ _____
Signature of Patient Date Signed