| E. Thomas Arne Jr., D.O., F.A.C.C.1250 S. Tamiami Trail Suite 401Sarasota, Florida 34239Office: 941-366-2194 Fax:941-366-7025[www.gulfshorepc.com](http://www.gulfshorepc.com)  |  |  | IMG_4682 |
| --- | --- | --- | --- |

**AUTHORIZATION TO DISCUSS MEDICAL INFORMATION**

**Health Insurance Portability and Accountability Act**

**(HIPAA)**

**Page 1 of 1**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize Dr. Arne and the Staff at Gulfshore Personalized Care to discuss my health and well-being with the following people listed below.**

**Name Relations**

|  |  |
| --- | --- |
|  | **Spouse** |
|  | **Children** |
|  | **Children** |
|  | **Children** |
|  | **Other** |
|  |  |

**This authorization will remain in effect until terminated by me in writing.**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**