Billing Disclosures to Individuals Involved in Patient's Care

There may be times when it is necessary for an individual directly involved in your care to call the facility or the Billing Office to inquire about your personal health or billing information. Please take a few moments to complete this form.

I authorize Monmouth Rehab Professionals to disclose my health information that is directly related to my current treatment at Monmouth Rehab Professionals to the individual (s) listed below for purposes of their role in m treatment or payment for the health services that I received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME: **RELATIONSHIP:**

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I do not wish to have my health information disclosed to individuals involved in my care.

NAME:________________________RELATIONSHIP:______________________

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SIGNATURE OF PATIENT (OR PATIENT'S REPRESENTATIVE) **DATE**

If you are a representative of a patient, check the scope of your authority to act on patient's behalf:

POWER OF ATTORNEY GUARDIAN SURROGATE DECISION MAKER
EXECUTOR OF LEGAL REP PARENT OTHER (PLEASE SPECIFY)_____________