

Dr. Edward Negovetich  
Authorization to Discuss And/Or View Protected  
Health Information with Others

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If Patient is a Minor-Parent's Names: \_\_\_\_\_

The Office of Dr. Edward Negovetich understands there may be times when other individuals may request information regarding your health care, such as a caregiver, attorney or spouse. In this instance, the protected health information for the patient cannot be disclosed without authorization. In order to allow other individuals to call, request or view information we need this form completed. Please review this authorization and list those individuals that may contact us for your protected health information.

**AUTHORIZATION**

I give my permission for the office of Dr. Edward Negovetich to discuss any protected health information (PHI) about this patient regarding treatment, payment and healthcare operations using the minimum necessary standards to the following individuals:

\_\_\_\_\_  
Name of Individual and relationship to Patient

\_\_\_\_\_  
Name of Individual and relationship to Patient

\_\_\_\_\_  
Name of Individual and relationship to Patient

\_\_\_\_\_  
Name of Individual and relationship to Patient

With this authorization, I am acknowledging that I understand that the office of Dr. Edward Negovetich will discuss my protected information (PHI) with the individual(s) noted. This authorization is valid indefinitely unless revoked in writing

\_\_\_\_\_  
Patient/Guardian Signature Date