HARRINGTON
+ ASSOCIATES

PATIENT STICKER

PATIENT COMMUNICATION DESIGNATION

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information (please print clearly):

_____

Last Name *First Name* *Middle Initial*

_____

Primary Contact number *Email address*

I authorize Harrington + Associates to disclose Protected Health Information to the following persons:

_____

Name *Phone Number*

_____

Name *Phone Number*

Information to be disclosed

☐ All Medical Information ☐ Other:_____

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Harrington + Associates. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Harrington + Associates cannot require me to sign this authorization as a condition of treatment. I understand that I will be given a copy of this authorization.*

Patient/ Representative Signature:_____

Date:_____