



Patrick J. Naples, M.D.
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PATIENT AUTHORIZATION FORM

I hereby authorize Summa Physicians, Patrick J. Naples, M.D., to use or disclose specific information listed below on to the persons listed below.

INFORMATION TO BE USED OR DISCLOSED:

	YES	NO
Account Information (i.e. balance, payment)	_____	_____
Medical Information (i.e. diagnosis, prescriptions)	_____	_____
Appointment Information (i.e. date, reason)	_____	_____
Surgery or Testing (i.e. date, times or changes)	_____	_____

PERSONS TO RECEIVE INFORMATION:

Name	Relationship	Phone Number
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

This information will remain in effect from the date signed below until:

_____ (fill in expiration date)

_____ no expiration date

I understand that I may inspect or copy the protected health information to be used or disclosed. I may revoke this Authorization at any time, in writing or by contacting your Privacy officer at the above phone number.

Patient Name

Date

Patient Signature

Relationship if signed by legal guardian