

**Consent for Disclosure of Patient Accounting Information**  
(Spouse, partner, office manager, adult child's parents, etc.)

I, \_\_\_\_\_, authorize the following person(s) to  
have access to my / my minor child's (circle one) patient account information.

This information may include charges, payments, dates of sessions attended, cancelled appointments, missed appointments, services provided, diagnosis, insurance claim transactions, insurance data, managed care authorizations, account balances, contact information, and other bookkeeping data related to reimbursement for services rendered by Whiteside and Daniel, P.A. This consent does not authorize release of clinical records such as diagnostic intake summaries, progress or session notes, test results, correspondence with other providers, etc. This information may be shared (check all that apply):

In writing       E-mail       Fax       Orally       In person

Specify below WHO may receive your account and billing information:

<u>Person</u>	<u>Relationship to patient</u>
Eg. Joe & Sue Smith	Parents

- 1.
- 2.
- 3.
- 4.

This authorization will remain in effect until termination or written notice is received by Whiteside & Daniel, P.A. except to the extent action has already been taken on the basis of this release.

Signed: \_\_\_\_\_ Adult Patient or Minor's Parent Date: \_\_\_\_\_