Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Health Information Disclosure

Date: ___/___/_____

I (patient name printed) _____, hereby give my permission to Dr. Mary Bell Vaughn and staff at Vineville Internal Medicine to release my personal health information to the following:

Name (printed): _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

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DOB: ___/___/____ & Contact Number: _____

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DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

I also understand that it is my responsibility to keep Vineville Internal Medicine informed of any changes of names on this list and must complete a new form each time I am in the office.

Patient DOB: ___/___/_____

Patient Signature: _____

Office Witness Signature: _____

Account#: _____