Account Authorization Form

I ___________________________________ authorize __________________________________
(Client Name) (Authorized Person)

To use and disclose the following protected information:

☐ Schedule/Cancel Appointments

☐ Discuss Billing and Insurance Information

☐ Discuss Health-Related Questions

☐ Order/Pick-up Apothecary Items

☐ Other_________________________

This authorization is effective through (Check-One):

☐ _____ / _____

☐ **No Expiration** unless revoked or terminated by the patient or the patients personal representative

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to:

Sojourns Community Health Clinic
4923 US Route 5
Westminster, VT 05158

____
Client Name (Printed)

___________________________________ ___________________________
Client Signature **Date**