BENNETT PEDIATRICS, LLC
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Clermont, FL 34711-6532
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COMMUNICATION USE & DISCLOSURE AUTHORIZATION

Date: _____/_____/_____

Patient: _____ Parent/Guardian: _____
(PRINT NAME) (PRINT NAME)

Date of Birth: _____/_____/_____ Patient #: _____

Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

□ Referral Information □ Prescription Refill Information □ Test Results

□ Other _____

You may discuss information regarding my treatment and care with the following family members and/or friends:

_____

_____

_____

_____

You may contact me regarding my or my child's treatment and care at the following numbers:

_____

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Staff Member: _____

Staff Signature: _____