Next Century
MEDICAL CARE LLC • By Nurse Practitioners

Authorization to Discuss Protected Health Information

I _____ authorize Next Century Medical Care, LLC to release or discuss information related to my medical condition (including information related to my treatment plan, medical information and/or billing information) to the following named persons:

1. Full Name: _____
   Phone Number: _____
   Relationship to Patient: _____

2. Full Name: _____
   Phone Number: _____
   Relationship to Patient: _____

3. Full Name: _____
   Phone Number: _____
   Relationship to Patient: _____

4. Full Name: _____
   Phone Number: _____
   Relationship to Patient: _____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this listing at any time. **You are not required to list any name if you do not so choose.**

Patient's Signature: _____ Date: _____

Printed Patient Name: _____ DOB: _____

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