Due to HIPAA regulations, we only will share your information with the person(s) that you specify. Please list all individuals below that you authorize us to discuss treatment, including financial information.

1. _____ Relationship INSURANCE COMPANY
2. _____ Relationship Spouse/Significant Other
3. _____ Relationship
4. _____ Relationship
5. _____ Relationship

I do authorize the office of Dr. Al Villalobos to discuss necessary information when requested by one of the above individuals. I may revoke my permission to any individual at any time in writing.

_____ _____

Patient/Parent or Guardian Signature Date