HEALTH INFORMATION ACCESS

The following names are of people, including myself that I would like to be involved in or have access to the above-mentioned patient's protected health information. I give permission for Dr. Aaron Land to share the above-mentioned patient's protected health information with:

NAME	RELATIONSHIP	LAST 4-DIGITS OF S.S. NUMBER
NAME	RELATIONSHIP	LAST 4-DIGITS OF S.S. NUMBER
NAME	RELATIONSHIP	LAST 4-DIGITS OF S.S. NUMBER
NAME	RELATIONSHIP	LAST 4-DIGITS OF S.S. NUMBER

PATIENT OR PARENT SIGNATURE _____ DATE _____

NOTE: If you wish to add or terminate information access to or from the above list, you must submit your request in writing to our office.