



Permission to Communicate

I understand that I have the option of providing CEENTA with a list of caregivers with whom CEENTA may discuss my appointments, referrals, test and lab results and any other health/financial information.

I, _____, give permission to CEENTA to share health/financial information with the below named caregivers.

Name	Phone Number	Relationship

I, _____, do not give permission to CEENTA to share health/financial information other than what has been outlined in the Notice of Privacy Practice.

I understand that I may revoke this authorization, in writing, at any time. The revocation will be effective as of the end of the day on which I provide it in writing to CEENTA's Privacy Officer. If I revoke my permission, CEENTA will no longer use or disclose medical information about me for the purposes that I previously had authorized in writing. I understand that CEENTA is unable to take back any disclosures already made with my permission, and that CEENTA is required to retain records of the care provided to me.

PATIENT SIGNATURE

DATE: _____

PRINTED NAME