Sojourns
COMMUNITY HEALTH CLINIC

Account Authorization Form

I _____ authorize _____
(Client Name) (Authorized Person)

to use and disclose the following protected information:

- ☐ Schedule/Cancel Appointments
- ☐ Discuss Billing and Insurance Information
- ☐ Discuss Health-Related Questions
- ☐ Order/Pick-up Apothecary Items
- ☐ Other _____

This authorization is effective through (check one):

- ○ _____ / _____
- ○ **No Expiration** unless revoked or terminated by the patient or the patients personal representative

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to:

Sojourns Community Health Clinic
4923 US Route 5
Westminster, VT 05158

By typing my name into this box, I hereby agree that this action constitutes my electronic signature.

Client Signature: _____ Date _____