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Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below. Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results ___Medications
___Lab Tests/Results ___Care Plan ___Summary of Medical Record
___Other (specify): ____________________________________

Indicate Confidential Information:
___Mental Health ___HIV information ___ Alcohol/Drug Information

Patient Name: ____

Date of Birth: ______________________________

Information to be given to:

Individual #1:	Individual #2:
Name: __________________________________	**Name:** ____________________________________
Relationship: _____________________________	**Relationship:** _______________________________
Phone: __________________________________	**Phone:** _____________________________________

This authorization shall remain in effect from the date signed below until (please check one):
□ _____________(specify expiration date or event) □ NO EXPIRATION DATE

I understand that:
I may inspect or copy the protected health information to be used or disclosed. • I may revoke this authorization in writing by contacting your office, attention Administrator. • This authorization is giving Health Center Name the right to discuss my medical information with the one or more people listed above. • Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA. • I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)

Patient Signature: ____ **Date:** _________________