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AUTHORIZATION TO DISCUSS MY MEDICAL CARE WITH A FRIEND OR FAMILY MEMBER

Patient Name: _____ DOB: _____

Address: _____ SS#: _____

Phone # (day): _____ Phone # (night): _____

Please discuss my medical care with:

Relationship:

Phone #:

Information that can be discussed:

() All information in my medical record.

() All information in my medical records concerning treatment provided for the specific condition(s) as follows: _____.

() All information in my medical records concerning treatment provided between the following dates: _____ and _____.

Purpose: _____

I may revoke this authorization in writing at any time (except to the extent that action has already been taken in reliance upon it). Unless revoked or renewed this authorization will expire on _____. If an expiration date is not specified, this authorization will expire in one (1) year from the date signed.

I understand that discussion of my medical record (in whole or in parts) may include information about alcohol and substance use/abuse, psychiatric or psychological problems, HIV*, AIDS, sexually transmitted diseases, pregnancies, genetic testing and other sensitive information.

I authorize the discussion of information in my medical records as specified above.

Signature of Patient

Date

Signature of Witness

Date

* Human Immunodeficiency Virus that causes AIDS