HITCHCOCK
FAMILY MEDICINE

Authorization to Discuss Medical Care

PATIENT INFORMATION:
Name/s (print) DOB

_____

_____

_____

INDIVIDUALS WITH WHOM INFORMATION MAY BE DISCUSSED:

_____

_____

_____

_____

INFORMATION TO BE DISCUSSED: (check one)
_____ All medical records
_____ Specific information (please specify):

PATIENT AUTHORIZATION:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be discussed, unless otherwise noted above.

MY RIGHTS:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian, or Authorized representative)

This authorization will expire one year from the date signed, unless otherwise noted or cancelled.