HITCHCOCK FAMILY MEDICINE

Authorization to Discuss Medical Care & Coordination

This form allows Hitchcock Medical Group to discuss aspects of your medical care with designated individuals. It is commonly used when a patient turns 18 and wishes to allow continued discussion of care with a parent or guardian, or when a patient authorizes an assistant or caregiver to help coordinate care.

PATIENT INFORMATION:

_____ _____
Full Name Date of Birth

_____ _____
Phone Number Email Address

INDIVIDUALS AUTHORIZED FOR DISCUSSION:

List the individuals with whom information may be discussed. This authorization applies only to discussion of information and does not permit release of written medical records.

_____
Name
Relationship to Patient: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Caregiver ☐ Other: _____

_____
Name
Relationship to Patient: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Caregiver ☐ Other: _____

_____
Name
Relationship to Patient: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Caregiver ☐ Other: _____

INFORMATION THAT MAY BE DISCUSSED:

☐ General medical care and treatment plans
☐ Test results and follow-up recommendations
☐ Appointment scheduling and care coordination
☐ Billing or administrative questions
☐ Specific limitations (please specify):_____

PATIENT AUTHORIZATION:

I understand that my medical information may include information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, mental health conditions, or drug and/or alcohol use. I authorize discussion of applicable information as selected above.

MY RIGHTS:

I understand that I am not required to sign this authorization to receive treatment or benefits. I may revoke this authorization in writing at any time. Once information is disclosed verbally, it may no longer be protected by federal privacy regulations.

SIGNATURE:

_____ _____
Signature (typed name accepted for electronic submission) Date

This authorization will expire one year from the date signed unless revoked earlier in writing