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 ____ Summary of Medical Record ___Care Plan

___ Other (specify): _____

Indicate Confidential Information:

____Mental Health ___HIV information ____ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship:_____

Address:_____

Phone:_____

Email:_____

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 do not have to sign this form in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I also understand that this authorization is giving Parker Family Care the right to discuss my medical information with the one or more people listed above but I may revoke this authorization in writing by contacting the PFC office.

Finally, I understand the 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.

_____

Patient or legally authorized individual signature Date

_____/_____

Printed name if signed on behalf of patient Relationship to patient (Parent, legal guardian, personal representative, etc.)