CHC Community Health Center OF SNOHOMISH COUNTY

Authorization to Discuss Protected Health Information

Patient Name: ______________________________ Date of Birth: ____________________

I give permission for my provider or clinical support staff to discuss my health information with the following listed people:

Name: _______________________________ Relationship: ___________________________

Name: _______________________________ Relationship: ___________________________

Name: _______________________________ Relationship: ___________________________

Items that I DO NOT give permission to discuss are checked below (items not checked may be discussed with those listed above):

- ☐ HIV/AIDS
- ☐ Sexually Transmitted Disease/Infection (STD/STI)
- ☐ Alcohol/Substance Abuse
- ☐ Mental Health

I also give permission to leave detailed voice messages at the following phone numbers:

1. _________________________________
2. _________________________________
3. _________________________________

NOTE: It is the patient's responsibility to keep this information current.

This form is good for **12 months** from the date signed and may be canceled at any time.

___________________________________ _______________

(Patient's Signature) (Date)

I understand I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in dependence upon it.

______________________________________ ______________________

Signature to Revoke Authorization Date