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 /remove** this authorization, in writing, at any time, except to the extent that action has been taken in dependence upon it. Only sign if you want this revoked/removed.

_____ _____

Signature to Revoke Authorization Date