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 and allow staff to leave a detailed message on their phones:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Items that **cannot be discussed** with this document and require the use of a Release of Information Form are the following:

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

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