

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

1. By my signature below, I hereby authorize the disclosure of

_ My Name _____

_ My Child's Name _____

Protected health information (including my HIV/AIDS related information, if any) to the person(s) listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient's Signature: _____ Date: _____

2. By signing below, I hereby authorize the practice to leave

_ My Name _____

_ My Child's Name _____

Protected health information including, but not limited to results, prescriptions and appointments on **answering machine**.

Patient's Signature: _____ Date: _____

3. By signing below, I hereby authorize the practice to leave

_ My Name _____

_ My Child's Name _____

Protected health information including, but not limited to results, prescriptions and appointments with:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient's Signature: _____ Date: _____

4. By signing below, I hereby authorize the practice to **fax**

_ My Name _____

_ My Child's Name _____

Protected health information to the following number: _____

Patient's Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES SIX (6) MONTHS FROM THE EFFECTIVE DATE ABOVE.