# 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: _____

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 may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving my medical providers the right to discuss my medical information with the one or more people listed above.
- 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.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature:_____Date:_____