

## Authorization to Discuss Medical Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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 dates/times  diagnosis  X-ray results  medications

lab tests/results  summary of medical record  care plan

Indicate Confidential Information (initial):

mental health  HIV Information  alcohol/drug information

Information to be given to:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

This authorization shall remain in effect from the date signed below until (please select one):

Date: \_\_\_\_\_

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 Canyon Family Health the right to discuss my medication 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).

Patient Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_