Authorization to Discuss Protected Health Information*

I, ______________________________ , authorize ______________________________

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to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**:

1. ____________________________ 3. ____________________________

2. ____________________________ 4. ____________________________

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- *PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
- **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

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Please list phone numbers where you would like us to contact you for:

- Results - lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. ____________________________

2. ____________________________

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Patient's name: ______________________________

DOB: ______________________________

SS#: ______________________________

Date: ______________________________

Patient's Signature: ______________________________

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ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE/LIVING WILL? ______________ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

IF NO, PLEASE LET US KNOW IF YOU REQUIRE INFORMATION.