AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____ Medical Record #: _____

Former Name or Alias (if any): _____ Social Security #: _____

Daytime Telephone: _____ Birth Date: _____/_____/_____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I hereby authorize _____

_____

and/or Dr.(s) _____ to discuss my medical information with the following individuals:

Name:	**Relationship to Me:**	**Phone#:**

Expiration date of authorization or event: _____

Patient may revoke this authorization at any time by verbal or written request.

SIGNATURE OF PATIENT AUTHORIZING DISCUSSION OF HIS/HER PERSONAL HEALTH CARE INFORMATION WITH THE ABOVE NAMED INDIVIDUALS:

Date/Time	Signature of Patient or Legally Responsible Party	Relationship to Patient