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

Patient ID Sticker