

AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

PATIENT INFORMATION			
Patient Name:		Medical Record #:	
Former Name or Alias (if any):	Social Se	ecurity #:	
Daytime Telephone:	Birth Date:/		
AUTHORIZATION TO DISCUSS	MEDICAL INFORMATION: I here	by 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 authorize	zation at any time by verbal or wr	itten request.	
•	IORIZING DISCUSSION OF HIS/HI	•	
Date/Time Signature of	Patient or Legally Responsible Party	Relationship to Patient	

Title:	Authorization to Communicate Patient Protected	Version Effective Date:	08/02/2021
	Health Information (PHI)		İ
Document Owner:	Medical Records	Page	1 of 1
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