Authorization to Discuss Medical Information

Patient Name: _____

Date of Birth: _____

I hereby authorize Summit Family Health 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 times/dates ❒ Summary of Medical Record ❒ Diagnosis ❒ Billing
❒ Lab tests/Results ❒ X-ray Results ❒ Medications
❒ Care Plan ❒ Progress Notes ❒ Other_____
❒All listed above

Indicate Confidential Information:

❒ Mental Health ❒ HIV Information
❒ Alcohol/Drug Information ❒ Other _____

Information may be released to:

Name	Date of Birth	Relationship	Phone Number

This authorization shall remain in effect from the date signed until:

❒ _____ (specify the expiration date—typically 8 years)

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 Summit Family Health.
★ This authorization is giving Summit Family Health the right to discuss my medical information with the one (or more) individual(s) listed above.
★ Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
★ I may refuse to sign this authorization and treatment will not be conditioned on my providing this authorization.

Signature: _____ Date: _____

Relationship to Patient: _____
(If signed by Personal Representative of Patient)