Patient Name:

Provider:

ENC #: MRN #:

DOB: Age:

Gender / Sex: Appointment Date:

NAME OF OFFICE / PRACTICE: ____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), I, ________________________ authorize my provider, __________________________ to discuss my health information with the following individuals. I understand that before certain health information (such as HIV status, substance treatment and mental health treatment) may be discussed, I might be required to complete an Authorization for Release of Medical Information.

____ Relationship: ______________________

Phone number: ____________________________

____ Relationship: ______________________

Phone number: ____________________________

____ Relationship: ______________________

Phone number: ____________________________

____ Relationship: ______________________

Phone number: ____________________________

____ Relationship: ______________________

Phone number: ____________________________

____

Patient signature or legal representation Date