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: ____

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