Convenient Care
Family Medicine
Walk-in Clinic

Authorization to disclose healthcare information

Patient Name: _____ **Date of Birth:** _____

I authorize the following individual/individuals to have access to my healthcare information:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Relationship to patient: _____ Relationship to patient: _____

The request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates: _____
_____

□ All healthcare information

□ Billing and Insurance

□ Other: _____

□ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

This authorization may be revoked at any time by notifying the above named provider in writing.

I, _____, have received, read, understand, and agree to the Notice of Privacy Policy. I understand my patient rights and responsibilities pertaining to my protected health information.

Patient/ Guardian Signature: _____ Date: _____

Relationship to patient: _____