



PHI DISCLOSURE - UPDATE

Last Name (Patient) _____

First Name (Patient) _____ MI _____

Social Security # _____ Date of Birth ____/____/____

PHI DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below unless you notify us otherwise in writing.

Please specify anything that you do NOT want to be released:

I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol /drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer be protected by law. **Parents/Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STIs/STDs, and HIV under state law.**

Date _____ Patient Signature _____

Responsible Party Signature (required if patient is under 18):

Responsible Party – Adult present signing

Relationship to Patient _____

Last Name _____

First Name _____ MI _____

Social Security # _____ Date of Birth ____/____/____

Gender F M

Address _____

Apt/Unit # _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____