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 (_____)_____