Carson Medical Group

ADULT

Consent to Disclose Protected Health Information

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

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others or friends without this authorization.

By signing this authorization, I authorize Carson Medical Group to disclose protected health information about me to the following individual(s).

Please mark the type of access you would like them to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Patient Name: _____
(Please Print)

Patient Signature: _____ **Date Signed:** _____