

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

Authorization to Communicate Patient Protected Health Information (PHI) Island Hospital

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Patient ID Sticker