AUTHORIZATION TO DISCUSS
MEDICAL CONDITION AND TREATMENT PLAN

Name:_____ DOB:_____

Name of Health Care Provider:_____

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

☐ Yes **IF, YES WHOM**:

_____
Name

_____
Relationship

_____
Name

_____
Relationship

☐ No

You may revoke or modify this authorization at any time, but you must do so in writing.

Signature of Person
Or Legal Guardian:_____ Date:_____

Witness:_____ Date:_____

This authorization satisfies the requirements of Title 42 of the Code of Federal Regulations relating to public health and the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).