AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth: _____

Authorization to Disclose Information to Others:

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

❑ All health information about me created or received by Orchid Health, including medical records, case ormedical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

❑ All health information **except for**: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

Personal Communication Methods:

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

Home Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

Mobile Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

TERM: This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Patient or Authorized Representative Name (Please print) _____

Date of Birth _____

If authorized representative, please state relationship to patient _____

Signature _____ Date _____