AUTHORIZATION TO DISCUSS HEALTH INFORMATION

I,________________________________,_____________, authorize medical providers and personnel
(Name of Patient) (Date of Birth)

of Broadway Medical Clinic to discuss my protected health information (PHI) with the following persons:

Name_____________________________________Relationship________________Phone____________

Name_____________________________________Relationship________________Phone____________

Name_____________________________________Relationship________________Phone_____________

The purpose of this Authorization to Discuss Health Information form is to provide our patients an opportunity to permit the verbal release of their PHI.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to the Release of Information Coordinator at Broadway Medical Clinic and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization expires 730 days (2 years) from date signed.

Please sign and date

____ Date:_____________________

Signature of Patient/Personal Representative

PRINT Name of Patient/Personal Representative ____

Description of Representative's Authority: ____