AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
The Patient acknowledges and agrees that **Associates in Family Practice (AIFP)** may disclose the patient's protected health information and medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, healthcare surrogates, or have power of attorney on behalf of the patient.

1. Name_____ Relationship:_____

   Contact information: _____

2. Name_____ Relationship:_____

   Contact information: _____

3. Name_____ Relationship:_____

   Contact information: _____

May we leave test results on any of the following? (Please initial the device(s) of your choice):
___ Home Voicemail/Answering machine
___ Cellular Phone Voicemail
___ Work Voicemail/Answering Machine

Please complete if you are over the age of 18:
Signing this HIPAA disclaimer allows our office to release your medical information to your insurance company, treating doctors and/or anyone whom you have listed above. It does not allow us to release the specific items listed below unless you initial the item. The Patient agrees that **AIFP** may disclose the following type of information contained in the Patient's medical records initialed below:
___ HIV/AIDS Information
___Mental Health Information
___Substance Abuse Information
___Sexually Transmitted Disease Information
___If the Patient is under the age of eighteen (18), Pregnancy Information

The Patient retains the right to revoke this Consent at any time. Such revocation must be submitted to AIFP in writing.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative