Infectious Diseases, HIV & Hepatitis. Wound Care, Travel Health & Outpatient Infusion
Diplomats in Internal Medicine and Infectious Diseases

PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

DATE: ________________ PATIENT NAME: ______________________________

DOB: _________________

The following named individuals have permission to discuss my PHI with my healthcare providers(s) and/or his office staff as my medical condition may require. This includes, but is not limited to, appointments, treatment plans, laboratory and diagnostic studies; and other information related to my medical care, including alcohol and drug abuse, psychiatric care, HIV and AIDS.

____
Printed Patient Name

____
Patient Signature

Person(s) authorized by patient to discuss PHI:

____
Name

____
Relationship

____
Name

____
Relationship