Elpida Healing Center

Authorization to Discuss Medical Information

I hearby authorize you to use or disclose the specific information described below, for the purposes and parties also described below.

Description of the specific information to be discussed (please check boxes):

- ❏ Appointment Date/Times
- ❏ Diagnosis
- ❏ Diagnostic Results (X-rays, MRI, CT scans, etc)
- ❏ Medications
- ❏ Other (specify): _____
- ❏ Lab Tests/Results
- ❏ Summary of Medical Record
- ❏ Care/Treatment Plan

Indicate Confidential Information (please check boxes:

- ❏ Mental Health
- ❏ HIV Information
- ❏ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship: _____

Phone Number: _____

This authorization shall remain in effect from the date signed below until (please check one):

- ❏ _____ (specify expiration date or event)
- ❏ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Elpida Healing Center the right to discuss my medical information with one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPPA.
- I may refuse to sign this authorization and you will no condition treatment or payment on my providing this authorization.

Signature: _____ Date: _____

Relationship to Patient if signed by personal representative of Patient: _____