South Bay Medical Care, P.C. – Authorization to Disclose Information

Authorization to Disclose Information to Family Members and Other Persons Directly Involved in my Health Care.

I authorize the disclosure of my health information (including HIV / AIDS related information, if any – unless specifically directed on this form to exclude that information) to the following family members, legal representatives, and close personal friend(s), or other persons who may be involved with my care or payment of healthcare services on my behalf.

1.
Representative Name: _____ Relationship: _____

Phone Number: _____

2.
Representative Name: _____ Relationship: _____

Phone Number: _____

3.
Representative Name: _____ Relationship: _____

Phone Number: _____

4.
Representative Name: _____ Relationship: _____

Phone Number: _____

Would you like a hard copy of your HIPAA rights? Yes _____ No _____

I also authorize the disclosure of my health information (including HIV / AIDS related information, if any – unless specifically directed on this form to exclude that information) to any person identified by me in the course of my treatment to the extent such information is directly relevant to this person's involvement with my care or payment of healthcare service on my behalf.

_____ _____
Signature of Patient (or personal representative) Date

_____ _____
Printed Name of Patient (or personal representative) Date

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