

**Patient Consent to Release Protected Health Information**

Authorized by: Patient

Legal Guardian/POA \_\_\_\_\_

The Physician/Practice may use or disclose the following protected health information:

Please check all that apply:

- All test results
- The entire medical record
- Today's chart note only

The following protected health information is specifically exempt from disclosure (may not be shared):

Please check all that apply:

- All test results
- The entire medical record
- Today's chart note only
- Other: \_\_\_\_\_

The purpose of the use/disclosure is:

Please circle all that apply:

- Continued medical care
- Employer's use
- Family/spouse's employer's use
- School use
- Other: \_\_\_\_\_

This authorization is in force until:

- One year
- It is revoked in writing

Disclosure to:

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Others: \_\_\_\_\_

Okay to leave a voicemail at the following phone numbers: \_\_\_\_\_

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Relationship to patient