Carson Medical Group

Consent to Disclose Protected Health Information

Patient's Name: _____ **Date of Birth:** _____

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others, or friends, without this authorization. Please include them below if you would like to designate additional individuals to have this access.

A minor patient's parents or legal guardians will have access to the child's medical information, except when prohibited by law.

By signing this authorization, I authorize Carson Medical Group to disclose protected health information about me/my child to the following individual(s).

Please list each individual and mark the type of access you would like each individual to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Patient/Parent/Legal Guardian Signature: _____ **Date Signed:** _____

Parent/Legal Guardian Name: _____
(Minors Only) (Please Print)