tcc | The Children's Clinic
WELCOMING FAMILIES SINCE 1911

Consent to Disclose Medical Information 18 Years or Older

Patient Name (please print) _____ Birth Date _____

Patient Phone _____

Authorized Individual(s):

Full Name (please print) _____ Relationship to Patient _____

Full Name (please print) _____ Relationship to Patient _____

Full Name (please print) _____ Relationship to Patient _____

Full Name (please print) _____ Relationship to Patient _____

I have agreed to authorize certain individuals to participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for The Children's Clinic to disclose my personal protected health information (PHI) to the individual(s) listed above.

Please initial disclosure below:

_____ The Children's Clinic may disclose my medical information to the individual(s) listed when I am not physically present, including disclosures by telephone, fax, e-mail or regular mail.

_____ Refill/pick-up medication prescriptions

_____ Call for medical advice

_____ Schedule/cancel appointments

_____ Pick-up completed forms

Please initial below to authorize the release of the following information:

_____ Contraceptive management

_____ HIV/AIDS/STD evaluation/treatment

_____ Alcohol/drug abuse evaluation/treatment

_____ Psychiatric/mental health evaluation/treatment

The Children's Clinic will not disclose confidential information unless medically necessary.

I understand that this consent is valid until _____ and may be revoked by me at anytime by written notice to The Children's Clinic.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Access Revoked Signature _____ Date _____