diamond®
luxury healthcare

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Client: _____ Date of Birth: _____

I hereby authorize medical providers and personnel of Diamond Physicians North Carrollton to discuss my protected health information with:

_____	_____
Authorized Personnel Name	Relationship to Client
_____	_____
Authorized Personnel Name	Relationship to Client
_____	_____
Authorized Personnel Name	Relationship to Client

I understand that certain information cannot be released without specific authorization as required by State or Federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the client's diagnosis and treatment for HIV/AIDS

_____ Psychotherapy notes from a Psychiatrist or Psychotherapist

_____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires. If no date is chosen, then this authorization does not expire.

Unless specified above, this authorization will not expire from the date of signing. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by Federal law or State law. I understand that I have the right to refuse to sign this authorization.

_____	_____
Name of Client/Personal Representative	Signature of Client
_____	_____
Date	Description of Personal Representative's Authority

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