

Authorization to Discuss / Disclose Protected Health Information

I give Family Medicine Associates of Hamilton, Manchester, and Middleton, Massachusetts, permission to discuss **my entire medical record and billing information** with the following persons or agencies:

Name:	Relationship:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

OR

Please discuss / disclose **only the following specified information** to the above-named persons or agencies:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such notification to Family Medicine Associates.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding privacy of my protected health information.

This authorization expires on: _____ / _____ / _____

OR

This authorization will remain in effect until I revoke it in writing.

Print patient's name: _____ Date of birth: _____ / _____ / _____

Signature of patient (or parent guardian): _____

Date form signed: _____ / _____ / _____