Patient Authorization for Disclosure of Protected Health Information
Sharing of Treatment/Billing Information with Family/Friends

I, _____, _____, hereby authorize The Physician Network to disclose my
Patient's Legal Name *Birthdate*

individually identifiable health information as described below:

I authorize the following person(s) :

Name of person(s) and/or organization	Relationship	Phone Number

The following information may be disclosed: (please check all that apply)

- ❒ All treatment information to include diagnostic tests results and communications of provider recommendations.
- ❒ If only specific treatment information, please list: _____.
- ❒ Billing information.

**Please note that minimal information such as requests for return phone calls and appointment reminders are permitted without express consent from the patient in order to coordinate patient care.*

- ❒ **Special Limitations: Does this authorization exclude (check all that apply):**
  - ❒ HIV/AIDS test results (if part of the medical record)
  - ❒ Sexually transmitted diseases
  - ❒ Other exclusions (must be specific)_____

Reason for disclosure of the information: _____

This authorization will expire: _____
Expiration date or event (if no date provided, authorization will expire in one year)

Prohibition on Conditioning of Authorization: I understand The Physician Network will not condition treatment on my signing this authorization, unless I am receiving research-related treatment or the only reason the clinic is providing me with healthcare is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Redisclosure: I understand that the information disclosed according to this authorization may be redisclosed by the recipient of the information and may no longer be protected by federal law.

Revocation: I understand that I may revoke this authorization at any time by notifying The Physician Network in writing by sending a letter or a completed Revocation of Authorization form to the manager of the clinic at which I receive healthcare. I understand that if I revoke this authorization, it will not affect any actions that The Physician Network took before it received my revocation letter. For example, The Physician Network cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the The Physician Network Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered as valid as the original

_____ _____
Signature of patient or personal representative *Date*

Printed name & relationship of personal representative, if applicable:

_____