Consent to Discuss Protected Health Information

Patient Name:_____ Date of birth:_____

I give First Care Medical Center, LLC permission to disclose and/or discuss the selected medical and billing information regarding my protected health information (PHI) with the indicated individual(s) indicated on my behalf. ***(Mark all that apply)***

- ☐ Billing and payment information
- ☐ Medical information regarding services rendered, diagnosis, medications, and treatment plan
- ☐ Lab/test result
- ☐ Other:_____

First Care has my consent to disclose/discuss the selected information above with the following:

Name	Phone Number	Relationship to Patient

I understand that I may cancel my consent at anytime; furthermore, it will not change any information that has already been disclosed.

I understand that this form is optional and I do not have to sign; furthermore, I should only sign if I want my PHI discussed with another individual on my behalf.

This form **must be completely filled out in order to be valid; particularly the selected information First Care Medical has consent to share with the individuals indicated.*

This authorization for release of information is valid* from:

_____ to _____

**Note: authorization will automatically expire one year from the date signed.*

_____

Signature of Patient/Guardian Date Relationship to Patient

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