FORM 114 - R170621

Consent to Disclose Medical Information

18 Years or Older

Patient Name _____ **Date of Birth** _____

AUTHORIZED INDIVIDUALS

Authorized Individual Full Name	**Relationship to Patient**
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

I HAVE AGREED TO LET CERTAIN INDIVIDUALS PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE. THEREFORE, I HEREBY GIVE MY PERMISSION FOR SALEM PEDIATRIC CLINIC TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED ABOVE.

PLEASE INITIAL DISCLOSURE BELOW:

_____ SALEM PEDIATRIC CLINIC MAY DISCLOSE MY MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED WHEN I AM NOT PHYSICALLY PRESENT, INCLUDING DISCLOSURES BY TELEPHONE, FACSIMILE, E-MAIL OR REGULAR MAIL

_____ REFILL/PICK-UP MEDICATIONS

_____ CALL FOR MEDICAL ADVICE

_____ SCHEDULE/CANCEL APPOINTMENTS

_____ PICK-UP COMPLETED FORMS

(SALEM PEDIATRIC CLINIC WILL NOT DISCLOSE CONFIDENTIAL INFORMATION UNLESS MEDICALLY NECESSARY)

PLEASE INITIAL BELOW TO AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

_____ ALCOHOL/DRUG ABUSE EVALUATION/TREATMENT

_____ HIV/AIDS/STD EVALUATION/TREATMENT

_____ PSYCHIATRIC/MENTAL HEALTH EVALUATION/TREATMENT

I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME BY WRITTEN NOTICE TO SALEM PEDIATRIC CLINIC.

Signed by _____ **Date** _____

SPC ONLY

PCP _____

R _____ **D** _____

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