Authorization to Discuss Protected Health Information (PHI) with Family Members and Other Designated Individuals

Patient Name: _____ Date of Birth: _____

Authorization

I authorize Venice Avenue Dermatology and its workforce members to discuss my protected health information (PHI) with the individuals listed below.

Name	Can Discuss	Relationship	Phone Number
	❑ Finance ❑ Medical		
	❑ Finance ❑ Medical		
	❑ Finance ❑ Medical		
	❑ Finance ❑ Medical		
	❑ Finance ❑ Medical		

❑ NO ONE OTHER THAN MYSELF IS PERMITTED TO HAVE MY IFORMATION

This authorization shall expire one (1) year from the date of signature unless revoked earlier in writing by the patient.

Acknowledgment

By signing below, I authorize the practice to discuss my protected health information with the individual(s) identified on this form. I understand that this authorization is voluntary, may be revoked by me at any time in writing, and will expire as stated above unless revoked sooner. I understand that information disclosed under this authorization may no longer be protected from redisclosure by the recipient.

Patient Name: _____ Signature: _____

Date: _____

If signed by personal representative:

Representative Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____