Authorization of Disclosure of Information

Partners in Health COLLECTIVE

Patient Name: _____ **Date of Birth:** _____

I hereby request that the following person(s) be identified as participants in my care or payment process. I understand that I am authorizing Full Circle Family Medicine - PHC to disclose health care information to the person(s) identified below to facilitate their individual involvement in my healthcare. Full Circle Family Medicine – PHC will make a reasonable effort to provide only the necessary information to the person(s) for this use and disclosure.

Name	Relationship	Phone	Type of Information to be Released

Authorization of Treatment of Minors

I authorize the following person(s) to bring my son/daughter _____, to their medical appointment. I also authorize any medical treatment that is necessary.

Name	Relationship	Phone

If my son/daughter is age 16 or older: **(must check one)**

__ I authorize my son/daughter to be seen without an accompanying adult

__ I ***do not*** authorize my son/daughter to be seen without an accompanying adult

1. I understand that this authorization will: **(must check one)**

   __ expire 1 year from the date signed by the patient or patient's representative, or

   __ be effective for the lifetime of the patient unless revoked (or if a minor, until age 18)

   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying Full Circle Family Medicine - PHC in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Full Circle Family Medicine - PHC prior to their receipt of the revocation.

   Initials: _____

3. I understand that my treatment is not conditional upon whether I sign this authorization.

   Initials: _____

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Printed Name of Patient or Patient's Representative **Relationship to Patient**