CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO A DESIGNATED REPRESENTATIVE

Patient Name: _____

Date of Birth: _____ Social Security Number:_____

Address: _____

City, State: _____ Zip: _____

To be completed by Patient (*Select appropriate access*)

I,_____, hereby authorize Camelback Pediatrics to
Print Patient's Name
release protected health information regarding me or my condition/treatment to:

☐ Check box if you want to EXCLUDE any information about alcohol, drug use, any STD's including HIV

_____ my _____
Print Name of Representative *Relationship to Patient*

_____ my _____
Print Name of Representative *Relationship to Patient*

OR

I,_____, hereby **RESTRICT ACCESS** to any of my
Patient's Name
Protected health information to:

_____ my _____
Print Name of Person With Restricted Access *Relationship to Patient*

_____ my _____
Print Name of Person With Restricted Access *Relationship to Patient*

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of witness Date Signed

***NOTE TO PATIENT:** For confidentiality reasons we will ask your designated representative for their identification card and your date of birth.