Dr. Matthew H. Conrad

Permission to Disclose Information to Those Involved in My Care

I hereby authorize ***Dr. Matthew H. Conrad*** to disclose the following Protected Health Information (PHI):

_____Appointment times and dates

_____Test results

_____Other health information

To the following people because they are involved with my health care or payment:

_____Self

_____Spouse _____

_____Child_____

_____friend_____

_____other_____

In the following forms of communication:

_____Home phone _____

_____Work phone_____

_____Cellular phone_____

_____Mail

_____Home voice mail

_____Work voice mail

_____Home fax machine

_____Other_____

Lab Choice/Phone #_____/_____
_____/_____
_____/_____

Pharmacy/Phone #_____/_____
_____/_____
_____/_____

Patient Signature: _____Dated: _____

Patient Printed Name_____