

Dr. Matthew H. Conrad

Permission to Disclose Information to Those Involved in My Care

I hereby authorize Dr. Matthew H. Conrad, M.D. P.A., to disclose the following Protected Health Information (PHI):

\_\_\_\_ Appointment times and dates

\_\_\_\_ Other health information

\_\_\_\_ Test results

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

\_\_\_\_ Self

\_\_\_\_ friend \_\_\_\_\_

\_\_\_\_ Spouse

\_\_\_\_ other \_\_\_\_\_

\_\_\_\_ Child \_\_\_\_\_

In the following forms of communication:

\_\_\_\_ Home phone

\_\_\_\_ Home voice mail

\_\_\_\_ Work phone

\_\_\_\_ Work voice mail

\_\_\_\_ Cellular phone

\_\_\_\_ Home fax machine

\_\_\_\_ Mail

\_\_\_\_ Other \_\_\_\_\_

Lab Choice/Phone # \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

Pharmacy/Phone # \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Dated: \_\_\_\_\_

Patient Printed Name \_\_\_\_\_