Rehabilitation Specialists of Monroe

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Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

☐ Appointment Date/Time ☐ Diagnosis ☐ X-ray results

☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan

☐ Other (specify):_____

Indicate Confidential Information:

☐ Mental Health ☐ HIV information ☐ Alcohol/Drug Information

Information to be given to: Name:_____

Relationship:_____

Address:_____

Phone:_____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (specify expiration date) ☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Rehabilitation Specialists of Monroe the right to discuss my medical information with the person listed above.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.

Patient Name:_____ Date of Birth:_____

Signature:_____ Date:_____

Relationship to Patient (if signed by personal representative of patient):_____

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