HEALTHQUEST
Medical Practice

Authorization to Communicate Protected Health Information (PHI)

NAME OF PATIENT WHOSE PHI MAY BE DISCLOSED:

Patient Name: _____ Birth date: _____/_____/_____

Address:_____

Home Phone Number:_____ Cell Phone: _____

I hereby authorize Health Quest Medical Practice ("HQMP") to disclose and/or discuss information pertaining to my medical care and treatment as indicated below.

THIS INFORMATION MAY BE COMMUNICATED TO: (please print)

1._____
Name Phone Number Relationship to Patient

2._____
Name Phone Number Relationship to Patient

3._____
Name Phone Number Relationship to Patient

DESCRIPTION OF INFORMATION TO BE DISCLOSED (check one):

[ ] HQMP may disclose to and/or discuss with the above individuals any and all medical information related to the care and treatment provided to me by HQMP.

[ ] HQMP may disclose to and/or discuss with the above individuals my medical information related to the following conditions only:

_____

_____

[ ] OPTIONAL: Any information disclosed to and/or discussed with the above individuals shall be limited to the following treatment dates (enter dates):
From _____/_____/_____ To _____/_____/_____

TO BE READ AND SIGNED BY THE PATIENT:
I understand the following:

- I may revoke this authorization by providing written notice to HQMP.
- I understand that any information that is disclosed as a result of this authorization may be re-disclosed by the recipient(s) named above.

Patient Signature		Date
Signature of Patient's Representative	Relationship	Date