DOC TYPE

10044

VANCOUVER CLINIC
Authorization to DISCUSS Protected Health Information

Medical Record Number (internal use only): _____

*Name **(**please print clearly**):** _____

*Date of Birth: _____

Name: _____ Phone: _____

Relation to Patient: _____

Name: _____ Phone: _____

Relation to Patient: _____

Name: _____ Phone: _____

Relation to Patient: _____

***I authorize** Vancouver Clinic to **DISCUSS** the following information:*

_____ Any/All health care information in my record

OR

_____ Specific information only (list out): _____

_____

*Authorization valid until (specific date): _____ **OR** _____ until revoked in writing (indefinitely).

You may revoke this authorization at any time by filling out a Revocation Form available at Vancouver Clinic. If you revoke this authorization, Vancouver Clinic cannot undo disclosures already released under this authorization.

_____ _____
*Patient or legally authorized representative signature *Date

_____ _____
Relationship to Patient if signed on behalf of patient Printed name if signed on behalf of patient