ORLANDO HEALTH FAMILY MEDICINE

Authorization to Discuss Medical Care with Family Members and/or Other Individuals

Patient's Name:_____ Date of Birth:_____

I hereby authorize the physicians and staff members of Orlando Health Family Medicine to discuss the medical care of the patient named above with the people listed below. This may include, but is not limited to, releasing information related to psychiatric care, drug use, alcohol abuse, HIV testing, ARC and AIDS.

I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 (five) years unless revoked.

Name Relationship

_____
_____
_____
_____
_____
_____

Authorization to Leave Messages

In an attempt to preserve the confidential nature of the doctor-patient relationship, it is requested that you select the different location/persons with whom or where we may leave messages regarding appointments and other administrative matters.

Please select the options below that apply:

_____ Messages may be left on my answering machine.
_____ I may be called at work. (Telephone number: _____)
_____ Messages may be left with the following:
_____ Husband (Name: _____)
_____ Wife (Name: _____)
_____ Other (Name: _____)
Relationship

Special instructions (if applicable):

_____

_____

_____ _____

Patient's Signature *Date*