Davies Clinic

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Authorization to Discuss Medical Records

I, ____, give permission to
(patient name and date of birth).

________________________________ (relationship: __________________________)
(name of authorized person)

to discuss:

- ☐ Discuss general medical records
- ☐ Discuss lab/pathology
- ☐ Discuss x-ray
- ☐ Discuss mental health
- ☐ Discuss AIDS/HIV
- ☐ Discuss sexually transmitted disease
- ☐ Discuss high risk behavior

____________________________________ ______________________

Signature Date

Refusal to Discuss Medical Records

I, ____, decline to have my
(patient name and date of birth)

information released to any person besides myself.

____________________________________ ______________________

Signature Date

This Authorization expires on _____/_____/_____, or not later than one year from date of signature.