# Authorization to Disclose Protected Health Information

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ☐Yes ☐No (If yes, whom do you designate?)**

Full Name: _____

Address: _____

Phone number: _____

Relationship to patient: _____

**Information To Be Disclosed**:

Medical condition: _____

Treatment plan: _____

Other: _____

I understand that I may revoke or modify an authorization with regard to any family member or other individual designated in the above authorization and that the revocation or modification must be made in writing.

_____ _____

Signature of Person, Guardian or Surrogate Date

_____ _____

Signature of witness Date

**********

☐I hereby revoke the above authorization

☐I hereby amend the above authorization in the following manner: _____

_____

_____

_____

_____ _____

Signature of Person, Guardian or Surrogate Date

_____ _____

Signature of witness Date

SAMPLE