Martin's Point

# Consent Form

**Consent to Allow Verbal Communication Regarding Your Health Care With Another Individual**

**Patient Name:** _____ **Date of Birth:** _____

By signing below, I am allowing Martin's Point Health Care to discuss certain pieces of my health information with the specific individual of my choosing listed below:

**Name of individual authorized to discuss my health care:** _____

**Relationship to Patient:** _____

**Address:** _____ **Phone #:** _____

This consent remains in effect until it is revoked in writing or a new consent is executed in its place. This consent may be revoked at any time except to the extent any person has taken action in reliance upon this consent. Revocation must be made in writing to the facility releasing the information. Further details on revocation of this consent are included in the facility's Notice of Privacy Practices. This consent expires 12 months from the date of my signature(s) below unless revoked in writing or a new consent is executed in its place. During the 12-month period, Martin's Point may make subsequent disclosures to the recipient named above.

**MEDICAL INFORMATION checked below may be communicated:**

- ☐ Entire Medical Record (excluding sensitive information*)
- ☐ Immunization Records
- ☐ Office Visit Notes
- ☐ History and Physical
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports
- ☐ Diagnostic Reports
- ☐ Consultation reports
- ☐ Hospital Reports
- ☐ Other: _____

I, the undersigned, hereby consent to the release of the protected health information "checked" above:

**Signature:** _____ **Date:** _____

**SENSITIVE INFORMATION:***

By checking the (below) boxes and signing below—I do authorize the release of information considered to be sensitive. This information may include or pertain to treatment and/or diagnosis of HIV status, mental health issues (excluding psychotherapy notes), substance abuse or "Other" issues. I understand that I have the right to review any mental health information before release of such information.

- ☐ HIV
- ☐ Mental Health
- ☐ Substance Abuse
- ☐ Other: _____

**Signature:** _____ **Date:** _____