PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Graybill Medical Group to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	______________________________	________________
Children	______________________________	________________
	______________________________	________________
	______________________________	________________
Guardian	______________________________	________________
Caregiver	______________________________	________________
Sister	______________________________	________________
Brother	______________________________	________________
Friend	______________________________	________________
Emergency Contact	______________________________	________________
Other	______________________________	________________

You may discuss my (please check all that apply)

Visit Notes   Laboratory Results   X-rays   Reports   All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)__________________________ Patient Date of Birth______________

Patient/Guardian Signature__________________________________ Date___________________