PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO FAMILY MEMBERS AND FRIENDS

PATIENT NAME	DOB	TEL
ADDRESS		

I, the undersigned, hereby authorize providers and personnel at Diamond Headache Clinic to disclose all available protected health information about me to:

RECIPIENT NAME	RELATIONSHIP
RECIPIENT NAME	RELATIONSHIP
RECIPIENT NAME	RELATIONSHIP

- ✓ I understand that this request does not apply to: (1) certain PHI that is not held in Diamond Headache Clinic's medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.
- ✓ I request that this information be disclosed for the purpose of allowing the above named individuals to participate in my care and to understand my health condition and treatment options.
- ✓ This authorization will expire **five (5) years** after the date of its execution, unless expressly revoked by me at an earlier time.
- ✓ I understand that Diamond Headache Clinic may not condition my treatment on whether I sign this authorization.
- ✓ I understand that this authorization does not limit Diamond Headache Clinic's ability to disclose my protected health information to a family member, other relative, or a close personal friend not listed above as permitted under HIPAA.
- ✓ I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.
- ✓ I understand that I may revoke this authorization at any time. However, if I revoke this authorization, it will have no effect on actions already taken by Diamond Headache Clinic in reliance on this authorization.
- ✓ I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

SIGNATURE OF PATIENT/ REPRESENTATIVE	DATE
PRINT NAME OF SIGNER	RELATIONSHIP