Patient Authorization for Specific Disclosure of Protected Health Information (PHI) to Family Members and Friends

Patient Name:	Date of Birth:	Phone Number:
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:	