Permission to Discuss Protected Health Information

Patient Name:_____ Date of Birth:_____

Please list below anyone you give permission to receive information from the ***Free Clinic of Pulaski County*** regarding your care and treatment including (but not limited to) medical diagnosis, prognosis, test results, behavior/mental health and scheduled medical appointments.

Name	Telephone Number	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing this Authorization, I acknowledge that I am giving the ***Free Clinic of Pulaski County*** permission to contact/disclose protected health information to the person/s listed above.

I may withdraw permission for the ***Free Clinic of Pulaski County***, or a point of contact listed above at any time in writing or in person.

Patient Signature:_____Date signed:_____

Witness Signature:_____ __Date Signed:_____