carroll COUNSELING center

Authorization of Health Disclosure Form

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

Authorization to Disclose Health Information

I, _____, hereby **GRANT** permission for the following person(s) to:

1. **Obtain / discuss information regarding my care:**

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

2. **Speak with the provider, and/or staff on my behalf.**

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

3. **Pick up any information regarding the patient listed above including prescriptions.**

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

4. **Make / Cancel / Reschedule appointments.**

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

5. **Discuss financial matters.**

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

6. **Other (Please List):** _____

   Name: _____ Relationship to patient: _____
   Name: _____ Relationship to patient: _____

I hereby **DECLINE** permission for the following person(s) to provide or obtain information related to my care:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

_____ _____ _____
Patient / Guardian Signature Printed Name Date

Relationship to Patient: _____ **Office Staff Witness:** _____