Authorization to Discuss Medical Information

Patient Name: _____ DOB: _____

I give Metro Health and its' departments/employees, permission to verbally discuss my medical information with the following person(s). This is not an authorization to release medical records.

Name Printed	Relationship	Address

Medical information may include:

- Information regarding communicable diseases, Acquired Immunodeficiancy Syndrome (AIDS), Human Immunodeficancy Virus (HIV), Alcohol and drug abuse or mental health treatment.

I must notify Metro Health in writing if changes are needed. A new form must be filled out. The form with the most current effective date will be active.

This authorization is good until _____ or, if no date given, when changed in writing by me.

_____ _____ _____

Signature Effective Date Time

_____ _____ _____

Signature of Witness Date Time