Consent to Communicate with someone other than Patient About health and/or account information

Patient Name: _____ Chart #: _____

I understand this information may include information relating to: acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV infection); treatment of drug or alcohol abuse; or mental, behavioral health, or psychiatric care (excluding psychotherapy notes).

Purpose of disclosure: Help provide aide in my health care. Other: _____

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal or Texas privacy law once it is disclosed to the Recipient and, therefore may be subject to re-disclosure by the Recipient.

I understand Family Medical Group of Texarkana may not condition treatment on my completion of this authorization form.

This authorization will expire upon revocation by patient or patient's legal representative.

I may revoke this authorization form at any time**. Initials**: _____

I give Family Medical Group of Texarkana permission to communicate my health and/or account information to: (List any and all persons you give Family Medical Group of Texarkana permission to communicate with in the event you are unable to).

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship of patient giving representative authority to act for patient: _____

_____ _____

Witness **Date**