Date: ___________________________

I, __________________________________ give permission for Dr. ____________________________
(patient name)

and her staff to talk with ____, my
(name)

___________________________, about my medical condition.
(relationship)
This information may:

________ (**please initial**) include HIV (AIDS virus), Sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

________ (**please initial**) **NOT** include HIV (AIDS virus), Sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

I understand that this authorization will be good from _____/_____/________ to

_____/_____/_________. If at any time this authorization changes, I understand that I will need to give

written notice of that change.

______________________________________ ___________________________________
Patient's Signature Date

______________________________________ ___________________________________
Witness Doctor's Signature