

Stephenville Medical & Surgical Clinic, P.A.

- Authorization to Release Communication Regarding Health Care Information -

Check one or both box 1 and 2, or check box 3:

- 1) MEDICAL DISCLOSURE** - I authorize Stephenville Medical & Surgical Clinic, P.A. (SMSC) to discuss my **medical** history, diagnosis, treatment and prognosis with those listed below. I understand that this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.
- 2) FINANCIAL DISCLOSURE** - I authorize SMSC to discuss all information regarding my **financial** account status including but not limited to insurance related issues, current account balances and past due account balances.
- 3) NO DISCLOSURE** - I do not authorize release of any information regarding my medical or financial information.

If you checked box 1 and/or 2, list specific persons authorized to receive information:

- Spouse _____
- Children (over 18 years)

- Parent _____
- Other _____

This authorization will be (please check one):

- Valid indefinitely unless revoked by me.
- Valid for the period of time beginning _____ and ending _____.

Signature of patient or *Legally Authorized Representative Relationship to Patient Date

SMSC Employee Date

*For the purpose of this form, "Legally Authorized Representatives" include: 1) legal guardian, 2) agents authorized in a Medical Power of Attorney, 3) attorney or guardian ad litem appointed by the court, 4) attorney retained by the patient or patient's legally authorized representative, 5) parent or legal guardian of a minor, 6) a personal representative or statutory beneficiary if the patient is deceased, that is a spouse, adult children and patents of the deceased patient.