MINOR & JAMES MEDICAL, PLLC

Authorization for Release of Individually Identifiable Health Information to Designated Party

This authorization grants permission to the Designated Party(ies) named below to exchange my private medical information with Minor & James Medical, PLLC, and any authorized representative thereof, without restriction in terms of content, purpose, or means of transmission. This authorization includes, but is not limited to: making or confirming appointments; accessing any and all x-ray, laboratory, or test information; access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis, and treatment plans; direct discussion of my health with my doctor or other provider; and have access to my financial information as it relates to my health.

Patient Name (print): ________________________________ D.O.B.: ______________

Designated Party: ________________________________ Relationship: ______________

Designated Party: ________________________________ Relationship: ______________

Designated Party: ________________________________ Relationship: ______________

Designated Party: ________________________________ Relationship: ______________

Designated Party: ________________________________ Relationship: ______________

☐ This authorization will expire 1 year from the date signed by the patient or the patients representative; or

☐ This authorization is effective for the lifetime of the patient unless revoked in writing.

I understand that providing this authorization is voluntary.
I understand that my treatment cannot be conditioned on whether I sign this authorization.
I understand that it is my responsibility to notify my healthcare provider should I amend one or more of the designated parties listed above.
I understand that once this information is disclosed to the Designated Party(ies), the released information may no longer be protected by federal privacy regulations.
I understand that I may revoke this authorization at any time by notifying Minor & James Medical, PLLC, in writing. If I do revoke the authorization, it will not have any effect on any actions taken by Minor & James Medical, PLLC, prior to receipt of the revocation.

Signature of Patient: ____________________________________ Date: ______________

Printed name of authorizing entity, if other than patient: ____________________________

____________________ Relationship to patient: ____________________________

Signature of authorizing entity: ____

For Clinic Purposes Only:

1. Form must be on yellow paper.
2. File in the advanced directive section of medical record.