AbsoluteCARE
Medical Center & Pharmacy

Oakhurst
Medical Centers

Standing Authorization To Discuss Health Information With Designated Persons

Patient Name: _____
(first) (m. initial) (last)

Address: _____
(street address)

_____
(city) (state) (zip code)

Medical Record #: _____ **Birth Date:** _____

For this authorization, "My Health Information" means any and all information relating to my course of examination and treatment. I authorize AbsoluteCARE Inc. (ABC) and Oakhurst Medical Centers (OAK) to discuss My Health Information with:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment and any other related matters.

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, ABC/OAK will not disclose My Health Information as requested.
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to the office where my authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, sexually transmitted diseases, behavioral health, drug and alcohol use, gender identity, gender expression, etc.

Signature of Patient: _____ **Date:**_____

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____, confirm that I am the legally appointed representative for the patient. Circle relationship below:

**Parent with Parental Rights / Registered Kinship Care Relative / Court Appointed Guardian /
Legally Appointed Healthcare Agent / Medical Power of Attorney /
Power of Attorney with Right to See Medical Records / Surrogate Decision Maker**

Representative's Signature: _____ **Date:** _____
(Required)

Address: _____ **Phone:** _____

You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).