UC Health.
Orthopaedics &
Sports Medicine

DISCLOSURE TO FAMILY / FRIENDS

I hereby authorize ____
(Physician / UCP Practice) to discuss the following with the person/persons listed below.

( ) Billing
( ) Condition / Treatment / Plan of Care
( ) Diagnostic Test Results
( ) Lab results

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection, behavioral health services/psychiatric care, and treatment for alcohol and/or drug abuse*. I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be redisclosed by such person or entity.

Allowed person / persons:

Name	Relation
1) ___________________________________	______________________________
2) ___________________________________	______________________________
3) ___________________________________	______________________________
4) ___________________________________	______________________________
5) ___________________________________	______________________________

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information**.**

Patient Name / Legal Representative ____

Patient DOB: ____________

Signature ____ Date _____________