MERIDIAN MD
Family Medical Care

PERMISSION TO DISCUSS MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

I permit the medical offices of Meridian Health Services, their physicians, nurse practitioners, nurses, and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my/my child's medical care:

Name	Relationship	Telephone Numbers

- Health care information may include sensitive information including drug/alcohol testing, mental health information, HIV testing, communicable disease information, and sexually transmitted disease information, unless otherwise stated below in Exceptions.
  Exceptions: _____
- Release of information under this document is limited to verbal discussions and does not permit release of any written health information to the individuals named above. Please use the Authorization for Release of Information for written medical record requests.
- This authorization is valid until revoked in writing.
- If, at any time, I wish to change the person(s) listed on this Permission to Discuss Medical Information form, I understand that I must complete in writing a new Permission to Discuss Medical Information form.

_____

Patient/Legal Guardian Signature Date

_____

Printed Name

_____

Witness

Rev. 11/2015 jcb