

## AUTHORIZATION FOR VISITOR

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I, \_\_\_\_\_, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

- Entire Medical Record \_\_\_\_\_
- Office Visit \_\_\_\_\_
- Lab Result \_\_\_\_\_
- X-ray Results of Films \_\_\_\_\_
- Immunization Records \_\_\_\_\_
- GYN Records \_\_\_\_\_

<u>INCLUDE</u>	<u>EXCLUDE</u>		<u>INCLUDE</u>	<u>EXCLUDE</u>	
<input type="checkbox"/>	<input type="checkbox"/>	HIV and/or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	STD
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Records	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Assault Records

I authorize the presence of the following visitors:

- Name : \_\_\_\_\_  Relationship to Patient : \_\_\_\_\_
- Name: \_\_\_\_\_  Relationship to Patient : \_\_\_\_\_

- I understand that I will get a copy of this form after I sign it.
- I understand that this authorization will expire on the date signed.
- I understand that I may revoke this authorization at any time prior to, or during, my patient visit.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**\*\*\*\*\*CONFIDENTIALITY NOTICE\*\*\*\*\***

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