Brock Hughes
Medical Center

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION: **HIPAA General Consent**

Print Patient's Name: _____

Date of Birth: _____

- I understand that I may cancel this consent at any time, by writing BHMC, but canceling it will not affect any information that has already been released.
- I understand that I may change any person named on this form at any time that I wish to have my confidential medical information shared with.
- This authorization will only expire with a written notice to do so.

CAN A MESSAGE BE LEFT ON VOICEMAIL? **YES** or **NO**

Complete Question 1 **OR** 2-not both (only one signature)

1. I **DO NOT** AUTHORIZE BROCK HUGHES MEDICAL CENTER TO SHARE ANY OF MY HEALTH INFORMATION WITH ANYONE

   _____ _____
   Signature Date

2. I **DO HEREBY** AUTHORIZE BROCK HUGHES MEDICAL CENTER TO SHARE:
   (please check the statements that apply)
   ___any of my medical information, including information about:
   - Medical diagnoses and treatment
   - Mental health diagnoses and treatment
   - Pharmaceutical treatment (medications)
   - Drug & alcohol use, history and treatment
   - Sexually transmitted diseases (STD's), AIDS/HIV testing and treatment

   ___Any of my lab results
   ___My appointment dates, times and reasons for the visit(s)
   ___Only the following information (specify): _____

   WITH THE FOLLOWING PEOPLE:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature Date