



**CONSENT TO DISCLOSE
PROTECTED HEALTH INFORMATION
TO A DESIGNATED REPRESENTATIVE**

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City, State: _____ Zip: _____

To be completed by Patient (Select appropriate access)

I, _____, hereby authorize Camelback Pediatrics to
Print Patient's Name

release protected health information regarding me or my condition/treatment to:

☐ Check box if you want to EXCLUDE any information about alcohol, drug use, any STD's including HIV

Print Name of Representative my _____
Relationship to Patient

Print Name of Representative my _____
Relationship to Patient

OR

I, _____, hereby **RESTRICT ACCESS** to any of my
Patient's Name

Protected health information to:

Print Name of Person With Restricted Access my _____
Relationship to Patient

Print Name of Person With Restricted Access my _____
Relationship to Patient

Signature of Patient

Date Signed

Signature of witness

Date Signed

***NOTE TO PATIENT:** For confidentiality reasons we will ask your designated representative for their identification card and your date of birth.