Harney County Health Department
CONSENT TO DISCLOSE TO OTHERS

I, _____herby acknowledge that the following person is involved in my medical care:

Full Name_____

Address_____

_____

_____

Telephone_____

Relationship to Patient:_____

I herby grant permission for my medical provider at Harney County Health Department, to discuss the care and treatment regimen pertaining to the health condition(s) indicated below. I understand this information will only be released as long as my provider determines in good faith that such disclosure is in my best interest.

I acknowledge that I have ultimate authority to determine the course of my medical treatment, in consultation with my medical provider(s). This authorization does not permit the person listed above to any authority on the direction of my care. This authorization may be revoked by me at any time in writing, but such revocation will not be effective until received by my medical provider. This agreement will expire one year from the date signed if not previously revoked.

Medical conditions that this authorization pertains to:_____

_____

_____By initialing here, I am authorizing the above named person, access to ALL available medical and demographic information via Patient Portal.

_____By initialing here, I am authorizing the above named person, access to ALL available medical and demographic information via EMR while providing direct patient care.

_____By initialing here, I am authorizing the above named person, the right to request hard copies of my medical records on my behalf. I understand that any protected health information which is deemed sensitive according to HIPAA guidelines, such as mental health treatment, drug and alcohol treatment, and HIV/Aids treatment will NOT be released to anyone other than myself.

_____ _____

Patient Signature Date

_____ _____

Witness Date