SUMMIT PACIFIC
• MEDICAL CENTER •

Family and Friends Consent to Discuss Authorization Form

I understand that my healthcare information at Summit Pacific Medical Center is protected and I have received the copy of their Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Information Form.

In addition, Summit Pacific Medical Center may use or disclose information regarding the following conditions for the purposes of Case Management Services as appropriate

(Check all that apply).

- ☐ *Mental Health/Psychiatric Disorders (including depression)*
- ☐ *Chemical Dependency (drug and/or alcohol abuse/treatment)*
- ☐ *HIV/AIDS Virus*
- ☐ *Sexually Transmitted Diseases*

***A minor patient's signature is required in order to release information concerning care for:**

1) Conditions relating to minor's sexuality including, but not limited to: contraception, pregnancy and sexually transmitted diseases (age 14 and above)
2) Alcohol and/or drug abuse (age 13 and above)
3) Mental Health conditions (age 13 and above)

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date as I recognize that relationships and friendships may change over time.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Patient Name: _____ **Date of Birth:** _____/_____/_____

Patient Signature: _____ **Date:** _____/_____/____