Patient: _____
Date of Birth: _____
SC Number: _____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

1. **Authorized Individual:**

_____	_____	_____	_____
Authorized Individual	Date of Birth	Relationship	Phone Number

Please DO NOT include the following in this authorization:

____ Mental Health ____ Drug/Alcohol ____ AIDS/HIV Status

____ Other (please specify): _____

2. **Authorized Individual:**

_____	_____	_____	_____
Authorized Individual	Date of Birth	Relationship	Phone Number

Please **DO NOT** include the following in this authorization:

____ Mental Health ____ Drug/Alcohol ____ AIDS/HIV Status

____ Other (please specify): _____

I understand that the person (s) listed above are not health care providers, health plans, or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be further disclosed without obtaining my authorization.

3. **Pharmacy Release:**

I authorize that S'eclairer may obtain information from/release information to the pharmacy listed below for the purpose of coordination of care.

_____	_____	_____	_____
Pharmacy Name	Location	Phone #	Fax #

This release will be valid for one year from: _____ to _____

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my choices.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____