



What This Form Does:

Allows Lakeview Clinic to talk with the person(s) you listed about your care (appointments, updates, and selected health information).

What This Form Does NOT Do:

Does **not** allow them to get copies of your medical records. A separate authorization is required.
 Does **not** give them permission to make healthcare decisions for you.
 Applies to **verbal communication only** (in person or by phone).
 No patient portal access is included.
 You can **change or revoke this at any time** and choose what information is shared.

Patient Information			
Name:	Street Address:		
Date of Birth:	City:	State:	Zip:
MRN:	Primary Phone #:		

1. Individuals Authorized

I authorize the following individual(s) to receive information about my care and communicate with my healthcare team:

Name:	Name:
Relationship:	Relationship:
Phone #:	Phone #:

2. Information That May Be Shared

- Appointment scheduling and reminders
- General health information and treatment updates
- Test results and care plans
- Billing and insurance information
- All health information (unless otherwise restricted)

Sensitive Information (optional – patient choice)

- Mental health information
- Substance use disorder (alcohol/drug treatment) information (may require additional authorization under federal law)
- HIV/STD or other communicable disease information
- Psychotherapy notes (if applicable)

Patient initials: _____

3. Purpose of Disclosure

Information may be shared for purposes of care coordination, communication, and assistance with my healthcare.

4. Expiration

- One (1) year from the date signed
- On this date: _____
- Upon my written revocation

5. Patient Rights

I understand I may revoke this authorization at any time in writing and that this authorization is voluntary.

6. Signature

Signature: _____
 Printed Name: _____
 Date Signed: _____