SCH
Shenandoah
Community Health

Authorization to Discuss

I authorize Shenandoah Community Health Center to discuss my health information with the following:

1.) Name _____
Phone_____
Relationship_____

2.) Name _____
Phone _____
Relationship_____

This **does not include** information regarding substance abuse treatment, HIV or mental health treatment unless specifically granted below by **initialing** next to each item to be discussed.

_____Substance Abuse Treatment

_____HIV Treatment

_____Mental Health Treatment

_____Child Abuse and/or Domestic Abuse history

_____STD Treatment

This authorization is valid for one year from the date signed unless revoked by me in writing. I am not required to sign this authorization. It is my responsibility to notify Shenandoah Community Health Center of any changes to contacts or phone numbers. Shenandoah Community Health Center does not condition treatment, payment, or benefit eligibility on signing of this form.

Patient Name _____
Date of Birth_____
Phone #_____

Signature_____
Relationship / Legal Authorization if not Patient_____
Date_____