PERMISSION TO DISCUSS OR RELEASE CONFIDENTIAL INFORMATION

By completing this form, you will allow the staff of the Riordan Clinic to communicate with family members, health care providers, or others as deemed medically appropriate. If someone other than yourself is responsible for payment of your services, you will need to include their name on this list.

I, ____, grant permission to the Riordan Clinic to discuss or release confidential information related to my care with the following individuals:

NAME	RELATIONSHIP

This authorization is considered valid until revoked in writing or until the following expiration date: _______________

At the Riordan Clinic (Olive W. Garvey Center for Healing Arts and the Bio-Center Laboratory) protecting the privacy of your medical information has always been our policy. By signing this form, you acknowledge you have been presented with a copy of the "Notice of Privacy Practices" detailing how confidential information may be used and disclosed as permitted under federal and state law.

PATIENT'S NAME (PLEASE PRINT)	DATE OF BIRTH
SIGNATURE OF PATIENT OR GUARDIAN	**TODAY'S DATE**