**Disclosure Agreement**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize South Shore Concierge Medicine PLLC, d/b/a Concierge Medicine of the South Shore and their affiliates, Ms.Medicine, to discuss the following with the person/persons listed below who are involved in my care.

( ) Billing

( ) Condition/ Treatment/ Plan of Care

( ) Diagnostic Test Results

( ) Lab Results

I understand that this is a voluntary authorization, and it may include information related to AIDS, HIV infection, behavioral health services, psychiatric care, and treatment for alcohol and or drug abuse. I understand that the person that receives my Protected Health Information (PHI) is not covered by Federal Privacy Regulations, the PHI described below may be re-disclosed by such person.

|  |  |
| --- | --- |
| Allowed Person/ Persons | Date |
|  |  |
|  |  |
|  |  |

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been takin in reliance on this authorization or according to law.

|  |  |  |
| --- | --- | --- |
| Patient/ Legal Representative Printed Name | Patient/ Legal Representative Signature | Date |
|  |  |  |