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HIPAA Consent for Release of Medical Information
to spouse, relatives or friends

I, _____ hereby give my permission to ***Dr. Teitel/Dr. Lin,***
(patient name)

to *disclose private medical information* if I am *unavailable or incapacitated* for any

reason to : _____ . This party is my _____ .
(name of recipient(s)) (relationship to patient)

This includes excludes HIV-AIDS information. This agreement will remain in effect until I advise the disclosing entity in writing.

This agreement will remain in effect until I advise the disclosing entity in writing.

(patient signature)

(witness)

(today's date)

cc: chart