Cherokee Health Systems

For Office Use Only
Patient Name:
Location:
Chart #:
Date:
Entered in HIPAA Initials:

Permission to Communicate by CHS Provider

(Please Print)

I _____ give my permission for my provider(s) with Cherokee Health Systems to communicate with the following individual(s) in regards to: examination, diagnosis, and my treatment OR for the following specific purpose:

_____

This notice is to remain in effect for 12 months or until I give written notice stating otherwise.*

1._____

Relationship to Patient:_____

2._____

Relationship to Patient:_____

Patient Signature: _____ Date:_____

Witness: _____ Date:_____

*This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any communication prior to notification of cancellation.

This authorization does not serve as a consent to release documents.