MCHD - BREAST AND CERVICAL CANCER PROGRAM

Authorization to Discuss Protected Information

I, _____, authorize Maverick County Hospital District, Breast and Cervical Cancer Program to discuss information related to my case (including medical, medication information and/or billing information) to the following named persons:

1. _____
   Relationship_____
2. _____
   Relationship_____
3. _____
   Relationship_____

Please be advised that any person not referred to on this list will not be given any information related to your case. You may change, restrict or expand this listing at any time.

Print name:_____

Case #:_____

Signature:_____