BIHC
Belleville Integrative Health Centre

Permission to Discuss Confidential Health Information

Patient Name _____
Date of Birth _____

I give permission to Belleville Integrative Health Centre (B.I.H.C) to discuss the following medical and billing information about me:

(check all boxes that apply):

- ☐ Scheduling/appointment information
- ☐ Medical information, including symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency, including symptoms, diagnosis, medications and treatment plan
- ☐ Lab and Test Results
- ☐ Billing and Payment Information
- ☐ Other _____

Belleville Integrative Health Centre (B.I.H.C) has my permission to discuss this information with the following people :

	Phone
Family Doctor:	
Specialist:	
Family:	
Other:	

I understand that I may cancel this permission at any time, but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

Printed Name_____Signature_____

Witness Signature _____Date _____