Mitchell Clinic, Ltd.

818 W HAVENS MITCHELL, SD 57301
PHONE (605)996-7526 FAX (605)996-1808
www.mitchellclinic.ltd

AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Mitchell Clinic, Ltd. (billing, treatment, appointments, prescriptions,etc.). Examples include spouse, parent (if you are over 18), another family member, coach, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of medical records. I give my permission for Mitchell Clinic, Ltd. personnel to share information verbally regarding my treatment at Mitchell Clinic, Ltd. with the following person(s):

NAME:_____ RELATIONSHIP_____PHONE_____

NAME:_____ RELATIONSHIP_____PHONE_____

NAME:_____ RELATIONSHIP_____PHONE_____

The above authorization will expire on_____.

Do you have a durable power of attorney for healthcare? ☐YES ☐NO
IF YES, PLEASE PROVIDE A COPY TO THE OFFICE FOR YOUR MEDICAL RECORD

I acknowledge that the Notice of Privacy Practices is available upon request. Mitchell Clinic, Ltd. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mitchell Clinic, Ltd., 818 W Havens, Mitchell, SD 57301.

PATIENT SIGNATURE_____

PATIENT REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____

DATE_____