ADDENDUM TO THE LIST OF TREATING PROVIDERS IN THE AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH AND SOCIAL SERVICES INFORMATION

CLIENT NAME _____ CLIENT ID _____ DATE OF BIRTH: _____

For the avoidance of doubt, my "current, past, or future treating providers*" who may disclose information include, but are not limited to, the following providers:

_____

_____

_____

_____

_____

*A treating provider is an individual or entity that conducts diagnosis, evaluation, and/or treatment of the patient, or consultation with the patient, for any condition.

I authorize the providers listed above to disclose information to any County health information exchange for the purposes, uses, and in accordance with my data sharing preferences described in the "Authorization for the Use and Disclosure of Health and Social Service Information" form to which this Addendum is attached.

_____
CLIENT NAME

_____
CLIENT OR RESPONSIBLE PERSON SIGNATURE DATE

If this Authorization is signed by a person other than the client, please indicate the relationship.

_____
NAME RELATIONSHIP TO CLIENT

PATIENT HIM LABEL
NAME
DOB
FIN#
MR#
SEX on ID