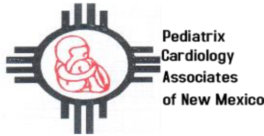

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1.____

2. ____

3. ____

4. ____

THE PRACTICE STAFF HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my: (Please check all boxes that apply)

☐ Home Voice Mail or Answering Machine — ☐ Home Phone number: ______________________________

☐ Cell phone — ☐ Cell phone number: ______________________________

☐ Work Voice Mail — Work phone number: ______________________________

☐ NO INFORMATION — ☐ **I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).**

______________________________ ______________________________

Print Name of Patient — *Print Name of Authorized Representative

______________________________ ______________________________

Patient/Authorized Representative Signature — Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

Parent/legal guardian Power of Attorney

*Evidence of authority must be provided and on file with the practice.