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.**