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. Mother _____ DOB_____

2. Father _____ DOB _____

3. Other _____ DOB _____

4. Other_ _____ DOB_____

___ Yes ___No The practice staff may have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff may have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

___□ Home Voice Mail or Answering Machine Home Phone number: _____

___□ Cell phone Cell phone number: _____

___□ Work Voice Mail Work phone number: _____

OR

___□ **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.