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 their judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA-complaint 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. ____

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   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.