Authorization for Release of Information to Family and/or Friends

---

Name of Patient ____ Date of Birth ______________

____ is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization.

________ Leave information on the voice mail. ________ Give information to spouse.

________ Give information to the following persons: ________________________________

Description of information to be released

________ Financial Information ________ Information results from tests or x-rays.

________ Family Billing Information

________Medical information as follows: ______________________________________

____

________ Other information as described: ______________________________________

____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to ______________________________________.
I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____ Date __________________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)