PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren) and others involved in care as applicable.

☐ You have permission to leave information on my answering machine regarding my medical care and test results.

☐ You have my permission to speak with my spouse about my medical care.

☐ You have my permission to talk with my children or other family members involved with me medical care.

☐ Other, please describe _____
_____
_____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Upon request, I may limit the amount of time that this consent for release of information is valid, I may revoke this authorization in writing, at any time. I understand that the revocation will not apply to information that has already been release. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____