Authorization to Disclose

Protected Health Information to Family and Friends

Release Information To Person Authorized to Receive Information (list one individual per form)

Name (First, Middle, Last)_____

Birth Date (mm-dd-yyyy)_____Relationship to Patient: _____

The individual named above is authorized to obtain information in the following manner(s) (check all that apply):

☐ Verbally: for example, via phone, face-to-face.

☐ Written or printed format: for example, medical record copies or the patient appointment guide.

☐ **DECLINE:**

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____