Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Simplicity Health to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

Patient Information

I understand 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.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____Date: _____

This authorization will expire one year from the date of signature unless I indicate a different date of event here: _____. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the above. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.