

Personal Healthcare Release Form

Please check one of the following statements:

□ I ***DO*** authorize the release of my personal healthcare information to (print name of specific individual and check relation)

□ Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Relative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other (i.e. friend, significant other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Information that can be released (please circle)

 Diagnosis, Medications, Lab Results, Appointments, Payment history

□ I ***DO NOT*** authorize the release of my personal healthcare information to any individual

Please note that if you choose not to disclose personal healthcare information to any individual it is possible that your healthcare may be delayed if we are unable to contact you directly. You may change or withdraw your authorization at any time in writing.

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Patient Name or Personal Representative (printed) Date

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Patient or Personal Representative Signature Date