**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization for Release of Information to Family and/or Friends:

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

White Bird Medical Clinic is authorized to release health information pertaining to the above-named patient to the entities below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Name** | **Relationship** | **Phone Number** | **Date of Birth** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

**Description of Information to be released**: please initial lines below

\_\_\_\_\_\_Financial Information

\_\_\_\_\_\_Results for, tests and/or x-rays

\_\_\_\_\_\_ 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 by sending written notification. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Any information received by this office for our own use will continue to be protected by the Federal and State Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that this form must be signed in clinic by the patient in front of a staff member to be considered a valid release. Witness initial \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Personal Representative Expiration date (1 year if not specified)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority (attach necessary documentation)