AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows(Nar		to communicate info	rmation
about your care (e.g., appointments, la	ne of Practice) bs, medication, tr	reatment plans, billing informatio	n) to you and
those you list on this form. Signing thi	s form is optiona	l, is not required to receive treatm	nent, and does
not expire until you end it in writing.	-	•	
Patient Name:			
Date of Birth:	,	^{irst)} tact Number: ()	(Middle Initial)
		☐ Home ☐	Cell* □ Work
Mailing Address:	(Street)		
(City)		(State) (Zip)
COMMUNICATING WITH Y	OU		
PHONE	DETAILED M	MESSAGES PERMITTED	
☐ Main Contact Number Above	□ text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: () ☐ Home ☐ Cell* ☐ Work	□ text (SMS)*	☐ voicemail/answering machine	☐ None
EMAIL*			
☐ All information from this practice☐ Appointment information only (r	e	☐ Data breach notifica	
COMMUNICATING WITH YO	OUR FAMILY	Y, FRIENDS, OR CAREG	IVERS
☐ This practice may communicate to the	e family members,	friends, or caregivers listed below.	
Spouse/Partner: First and Last Name		Other:	
		First and Last Name Phone: ()	
Phone: () Email:*		Email:*	
Linuii.		Relationship:	
Check the box next to each type of inform	nation this practice	II.	
☐ All information ☐ Prescriptions ☐ App	•	•	ce
☐ Other:			
Do not include:			
☐ Mental health records ☐ Communicable			
* I understand that emails and texts ar read by a third party. I am willing to This practice is not responsible for the recipient(s) listed above	accept this risk.	•	-

Page 1 of 2 Rev. 05/2022

10	UR PHOTOS & MULTIMEDIA	Photos/Images may be used/	nostad:
□ P1	hoto received from you or personal representative	☐ In office	posteu.
	hoto taken by staff (e.g., pre/post procedure)	☐ On office's website	
	Other:	☐ Other:	
PA ⁷	ΓΙΕΝΤ RIGHTS & SIGNATURE		
	You can end this authorization at any time in exceptions. A termination will not apply to any rel a written termination from you.	_	=
	The recipient of the information could use or release. This practice is not responsible for the privacy or sthose listed on this authorization.	<u>-</u>	-
•	You can review or copy the information that will be	e used or released as described in	n this authorization
•	You do not have to sign this authorization to receiv	ve treatment from this practice.	
	_	-	
	You understand that the information that will be disease diagnosis such as HIV or a diagnosis relate exclude it above.	used or released might include	
•	disease diagnosis such as HIV or a diagnosis relati	used or released might included to mental health or substance de in writing and signed by yo	e abuse unless you u (patient) or you
•	disease diagnosis such as HIV or a diagnosis relate exclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new phose)	used or released might included to mental health or substance de in writing and signed by yo	e abuse unless you u (patient) or you
• Pati	disease diagnosis such as HIV or a diagnosis relatexclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new photodated instead of requiring a new form.	e used or released might included the december of the december	e abuse unless you u (patient) or you form, initialed, an mm/dd/yyyy bower of attorney)
Patit	disease diagnosis such as HIV or a diagnosis relatexclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new phost dated instead of requiring a new form. ient/Personal Representative Signature nted name and description of Personal Representative.	e used or released might included the december of the december	e abuse unless you (patient) or you form, initialed, an mm/dd/yyyy
Patis	disease diagnosis such as HIV or a diagnosis relate exclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new photodated instead of requiring a new form. ient/Personal Representative Signature nted name and description of Personal Representative and tach documentation to support the personal representative's attach documentation to support the personal representative's attach documentation to support the personal representative and personal r	te used or released might included the december of the december of the substance of the december of the decemb	e abuse unless you (patient) or you form, initialed, an mm/dd/yyyy
Patit	disease diagnosis such as HIV or a diagnosis relatexclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new phost dated instead of requiring a new form. ient/Personal Representative Signature nted name and description of Personal Representative and documentation to support the personal representative's at the personal representative and description of Personal Representative and documentation to support the personal representative and description of Personal Representative and description description of Personal Representative and description descr	e used or released might included the december of the substance of the sub	e abuse unless you (patient) or you form, initialed, an mm/dd/yyyy
Patit	disease diagnosis such as HIV or a diagnosis relatexclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new phose dated instead of requiring a new form. ient/Personal Representative Signature nted name and description of Personal Representative and documentation to support the personal representative's attach documentation to support the personal representative's attach documentation to support the personal representative and personal represe	the original authorization.	e abuse unless you (patient) or you form, initialed, an mm/dd/yyyy
Patition (Att	disease diagnosis such as HIV or a diagnosis relatexclude it above. All changes or updates to this form must be made personal representative. Minor edits (e.g., new phose dated instead of requiring a new form. ient/Personal Representative Signature Inted name and description of Personal Representative and documentation to support the personal representative's attach documentation to support the personal representative's attach documentation has been terminated: The termination must be in writing and filed with the second content of the personal representative of the personal rep	the original authorization.	mm/dd/yyyy nower of attorney) practice)

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

Page 2 of 2 Rev. 05/2022