Permission to Share Protected Health Information with Family, Friend, or Caregiver

(Use Authorization for Disclosure of Protected Health Information form to share information with other healthcare providers or insurance companies)

Patient's Full Name: ______________________________ DOB: ____________

This authorization is given by: ______ Patient for self ______ Parent/Guardian

☐ I DO NOT wish to list anyone.

The physicians/practice may disclose protected health information to:
(examples- spouse, parents, children, caregiver, friend)

First & Last Name	Relationship	Phone Number

I understand that the Physician/Practice may disclose protected health information including the entire medical record. Specific exceptions, if any, are noted here: ______(Initials)

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I understand that the purpose of the use/disclosure is for continued medical care. ______(Initials)

I understand this authorization is in force until it is revoked in writing, and I may revoke authorization at any time in writing. ______(Initials)

A detailed message may be left on patient's voicemail/answering machine. ☐ YES ☐ NO

____

Printed name of patient/guardian Signature Date

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