Payne Nursing Services, LLC
5999 W Memory Lane
Greenfield, IN 46140
(317)779-1204 Fax (317)940-5759

HIPAA Authorization Form for Family Members/Friends. If you would like a copy of your medical record, you will need to complete a separate medical release form.

This consent for release of information is regarding (patient's name): ______________________________

I, ____, give permission/consent for Payne Nursing Services (including its providers, nurses, and therapists) to disclose and release the protected health information of my own, my child, or my legal ward to:
Name(s): Relationship:

_______________________________ ______________________________________

_______________________________ ______________________________________

_______________________________ ______________________________________

This information is to be held in confidence and used only to best serve myself and/or my family or legal ward. This health information may be used to enable the persons I authorize to know and understand my condition, my treatment, treatment options, for treatment consultation, for claims payment purposes, or related reasons.

This release will be null and void at the dismissal of services or at any time I decide to revoke the release. The release will be terminated once I advise all parties of the revocation both verbally and in writing.

____
Printed Name of the Individual Giving this Authorization

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Signature of Patient or Authorized Individual

Date: _____________________

Version	Date of Update	Changes	Updated By
1	01/19/2026	Document creation	Carla Payne, NP