Authorization for Release of Information

Name of Patient ____ Date of Birth _______________

____Conner Family Health Clinic_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others keeping with the patient's instructions.

Where/Who we may leave information:	**Which information may we leave:**
Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voicemail ❑ Email ________________________________	❑ Results of lab tests/x-rays ❑ Lab Results, Appointment Correspondence, Limited Medical Information
❑ Spouse (provide name and phone number) ________________________________	❑ Financial ❑ Medical as follows: ______________________
❑ Parent (provide name and phone number) ________________________________	❑ Financial ❑ Medical as follows: ______________________
❑ Siblings (Over the age of 18) ❑ Other (i.e. Stepparent, Grandparent, Children over the age of 18) ________________________________	❑ Financial ❑ Medical as follows: ______________________ ________________________________

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been 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 under federal law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until revoked by the patient.</u>

____ Date ______________________
Signature of Patient or Personal Representative

Revised May 2018